RA
412.4
.M4366
1987

HEALTH CARE FINANCING ADMINISTRATION
MEDICAID MANAGEMENT INFORMATION SYSTEMS

FY 1987 SYSTEM PERFORMANCE REVIEW

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

JUNE 1986

REPORTS
RA
412
.4
M4366
1987

11400. BACKGROUND AND AUTHORITY

Section 1903(r) of the Social Security Act provides an explicit basis for developing and applying performance standards to previously approved Medicaid Management Information Systems (MMIS). It requires HCFA to conduct standards-based reviews at least annually and to use the results of those reviews as the determining factor for both reapproval/disapproval of a State's MMIS and any resultant reductions in FFP levels. The reviews will be integrated, to the extent practicable, into the annual State Assessment process.

11405. SYSTEM PERFORMANCE REVIEW (SPR) - BASIC PURPOSE

The basic purpose of the SPR program for MMIS is to improve the effectiveness and efficiency of the Medicaid program on an individual State basis and for the program overall. Performance evaluation is based on the concept that an MMIS must meet specific functional requirements, as well as certain performance standards. Thus the evaluation system applies measures which enable determinations to be made as to whether or not a State system satisfies the functional requirements and statistical levels of output relating to accuracy and timeliness. Initial approval of a State's MMIS does not guarantee automatic reapproval. The reapproval process begins anew each fiscal year and is intended to measure sustained performance, as opposed to the capabilities assured by the initial approval review. The SPR is conducted by the regional offices (ROs) utilizing a standard format, as outlined in this package.

11405.1 Evaluation Mechanisms for States.—Paragraph 1903(r)(6)(D) of the Social Security Act requires HCFA to insure that review procedures, performance standards, and other requirements for MMIS reapproval be of a nature which will permit their use by the States for self-evaluation. Accordingly, in addition to meeting the statutory requirement that the States be notified in advance of those standards against which their MMIS will be measured, an underlying principle in both the issuance of the performance standards and the development of the accompanying instructions concerning assessment methodology has been to enable States to evaluate their own performance on an ongoing basis and take corrective action as needed. Thus, this section of the State Medicaid Manual (SMM) includes specific instructions on scoring, sampling, and methods of evaluation so that States may understand these techniques and apply them in conducting internal reviews of their own systems. States which wish to conduct internal SPRs might have to make adjustments in their record keeping or management information control systems. Upon request HCFA ROs will provide technical assistance to States in setting up such internal evaluation mechanisms.

11405.2 Automated File Search and Review Techniques.—Previous evaluation of the benefits and problems associated with manipulation of live files revealed that implementation of automated review procedures is beneficial to both HCFA and the States. Not only is the review burden eased for both, but States then have these processes available for ongoing use. Because the latter is an express objective of section 1903(r)(6)(D) of the Act, HCFA has required since FY 1984 that States provide automated sampling capabilities for the SPR. If an individual factor requires automated sampling, it is indicated in the method of evaluation. When requested, ROs will provide States with technical assistance on this issue.

11405.3 Content and Utilization of SPR Instructions.—The SPR package contains performance standards and review elements together with the methodologies for assessing whether they are met. These should not be interpreted as being the only requirements which a State's MMIS must meet. Rather, these are those standards of performance selected for review in a given year. Sampling methodologies used for evaluating various program elements are also included. Additional instructions designed to provide more detailed guidance to the reviewers and greater uniformity of reviews nationwide have been included in the HCFA Regional Office Manual. For MMIS States, SPR replaces the claims processing target areas of the State Assessment Guide. In addition, where an SPR factor duplicates a State assessment element in target areas other than claims processing, the SPR package takes precedence and the State assessment element will not be reviewed. SPR reviews MMIS operations as integrated into overall State Medicaid program administration. Consequently, the SPR may include assessments of functions which are not historically considered part of the MMIS per se, but which are so crucial to Medicaid operations that an otherwise effective MMIS is of significantly reduced value if State performance of the function is deficient. Effectiveness and efficiency are evaluated in consideration of the total State operation. Beginning in FY 1987, reviews will be based on a focused review methodology that will determine the factors to be reviewed in each State on the basis of individual factor characteristics and the importance to HCFA of the review factors, the State's past performance on each factor, and individual State program characteristics.

11405.4 SPR Factor Weights and Scoring System.—The review factors are weighted to reflect relative importance within each element. A scoring mechanism incorporating the weights is provided to determine the degree of acceptable or failing performance. The scoring mechanism contains a tolerance so that for most factors poor performance, to a limited degree, will not result in failure of an element. However, significant failure of certain factors may result in failure of an element. The scoring system provides bonus points for superior achievement in certain functions and penalty points for failure to meet minimum levels of acceptable performance. Bonus points are awarded only if the initial score for an element is passing. Penalty points are assessed against each factor and always figure into the final score for each standard. That final score permits HCFA to distinguish between the performance of the individual State systems and is the principal determinant in the decision of MMIS reapproval or disapproval.

11405.5 Scheduling of SPR Reviews.—Review of State performance may be scheduled at the discretion of the ROs in coordination with the States. However, special attention should be given to scheduling the review of problem areas such as failure of a standard or element during a previous review period and suspected problems which could cause failure of the SPR. In addition, State systems subject to SPR for the first time should be reviewed early against as many standards as possible in order to alert State management of any performance problems. States are provided ample notification of areas where the previous year's performance needs improvement. Final RO reports of SPR findings specify areas of the review where major problems, as well as failures, occurred. Also, the official HCFA notifications of MMIS reapproval and disapproval specify elements and standards failed during the review period. These notifications and/or early reviews of problem areas ensure State awareness of deficiencies in time to take remedial action. Certain factors, however, cannot be completely reviewed until the fourth quarter, e.g., Medicaid Minimum Data Set reports. All evaluations are based on performance from the beginning of the period until the date of review.

Standards are normally evaluated only once during a review period. However, equity requires HCFA to be sure that failure of a standard is not due to a premature conclusion on overall performance. If a standard is reviewed early in the year and meets requirements, the result is normally considered final. If, however, the State's early performance results in failure of the standard, a subsequent review based on at least six (6) months activity is conducted on those factors which were assessed penalty points. This procedure assures the States that any evaluation of deficiency is representative of overall performance. It also affords States an opportunity to correct problems so that overall performance for the review period may be acceptable. Where possible, failures should be fully explained in exit conferences. In any case, States are notified of initial findings of failure as early as possible. The RO and State work out, given State capabilities and RO staff resources, a mutually agreeable time for the rereview. Rereviews should be scheduled so that the States may take remedial action which would improve their annual performance rates. It is, however, impossible to conduct all rereviews late in the fourth quarter. Where agreement on a rereview date cannot be reached, the RO will schedule the rereview based on its best judgment as to the most appropriate time.

States should be aware that ROs will continue to monitor standards passed on early reviews to ensure that the State's performance in those areas continues at an acceptable level. If an RO, through such monitoring or other sources, has evidence that performance in an area earlier evaluated as acceptable may no longer meet performance standards, it may conduct a subsequent year to date review of affected factors.

11405.6 Availability of SPR Documentation.—Throughout the SPR, documentation must be available in States to support alleged procedures. Some States may need to modify their internal record keeping requirements in order to provide adequate documentation of system performance. Further, when ROs determine that proper conduct of SPR requires access to the raw data upon which reports, tallies, etc., are based, the State must provide such data. If a State lacks, or is unwilling to provide, the necessary supporting documentation, the State will not be automatically presumed to have met the SPR requirements. Without documentation to support that a function was performed, maximum penalty points will be assessed for the appropriate factor(s). Special funding will not be available to the States for costs incurred due to SPR. Finally, the State agency is ultimately responsible for meeting all standards, system requirements, or other conditions of reapproval as established by regulations. Thus, a State is not relieved of its responsibility merely because it uses the services of a proxy (fiscal agent, subcontractor, other State government component, etc.) to carry out certain functions.

The SPR results reflect the performance of States' MMIS and form the basis for resultant decisions on enhanced Federal funding levels. Because of the potential fiscal impact on States, it is imperative that the review methodologies and results for each factor found deficient be carefully documented by ROs to support their findings and conclusions.

11405.7 States' Flexibility Under SPR.—States have expressed concerns on the perceived use of the MMIS General Systems Design (GSD) as an SPR evaluation tool. The concept of demonstrable conceptual equivalence to MMIS requirements has been recognized since the inception of both MMIS and the SPR. This provision permits States to depart significantly from the GSD model so long as those changes satisfy the objectives and functions of the system requirements articulated in Part 11 of the SMM. This provides States sufficient flexibility to allow for the differing administrative needs of their various programs. State flexibility was further emphasized in the December 28, 1983 HCFA issuance to State Medicaid Directors describing the HCFA S/URS-MARS burden reduction initiative.

The SPR uses Part 11 as a source for basic MMIS requirements. However, changes in program needs require MMIS standards, systems requirements and guidelines to be subject to change at appropriate times. Consequently, what may have served as a demonstrable conceptual equivalent for FFP purposes at one time in a State, may necessarily be insufficient later on. This can also affect SPR performance if a previously accepted demonstrable conceptual equivalent is no longer justifiable in light of current reapproval requirements. The SPR is provided to the States by the end of June each year with an effective date of the following October. Thus, States have at least three (3) months advance notice of changes in the performance standards and review guidelines which might require modifications to State systems or procedures. States should read each new SPR carefully to identify potential problem areas. Questions concerning the proper interpretation of SPR requirements should be quickly directed to the ROs so as to permit maximum State reaction time.

11405.8 Other Mechanisms to Improve Performance.—State systems are expected to operate at the highest possible levels of efficiency and effectiveness. Marginally acceptable performance is not sufficient. While the SPR process is HCFA's principal vehicle for ensuring optimal levels of system performance, ROs have authorization to utilize, in addition to SPR, other oversight and remedial mechanisms. Examples of such mechanisms include focused reviews and corrective action plans. These may be used even where a State's MMIS has met all standards for reapproval. That is, a passing score on an individual standard does not absolve the State of its responsibility to continue to improve where possible. Nor does it absolve HCFA of its responsibility to work with the States toward that goal. However, system operational funding is not affected by these actions. Funding levels may be modified only in response to overall performance as determined in a formal SPR review.

11405.9 Monitoring Only Items.—New performance requirements may be added to the SPR at any point in the review cycle so long as their results cannot affect State funding. Such monitoring only items are often included to determine the feasibility of measuring a particular process or requirement in future SPRs.

11410. SYSTEM PERFORMANCE REVIEW (SPR) SAMPLING METHODOLOGY - GENERAL

SPR sampling follows a scientifically valid sampling method. There are four sample size schedules which may be used: expanded, intermediate high, intermediate low, and normal. In addition, there are alternative samples to be utilized for certain critical factors. Factors using expanded and normal sampling are so marked. Intermediate high and low sampling are used as derivatives of expanded sampling for the samples used to measure multiple factors. These sampling methodologies significantly limit the amount of work required in the selection and analysis of samples. The relatively small sample sizes broaden the range of acceptable performance for meeting the standards. That is, given the lower precision of small samples, the scoring system gives the full benefit of increased doubt to the States. This adjustment is built into the scoring charts.

Where a factor involves sampling, it is necessary to use the sample size chart. To use the chart, determine the universe size for the portion of the year under review. For example, if the factor is being reviewed in March 1986, determine the universe size for the period October 1985 through March 1986 (up to the point of review). The sample size used is found under the sampling plan column; i.e., expanded, intermediate high, intermediate low, or normal, in the same line as the universe size. For example, if the universe size is 350, the expanded sample is 70, and normal is 8. The only situation where universe size does not translate into various sample size groups is for factors having a prescribed large sample. The largest fixed sample will apply only to factors having an assumed large universe.

Intermediate high or low samples are required when the items measured are a subset of an existing expanded sample. The number of relevant items included in the expanded sample determines whether high versus low intermediate sampling and scoring is used. When 60 to 79 relevant items are sampled, use intermediate high sampling, when 40 to 59 relevant items are sampled, use intermediate low sampling. In either case, the number of items reviewed is exactly 60 or 40. This is achieved by randomly deleting excess relevant items to arrive at the highest possible intermediate sample size. Use the following procedure to eliminate excess items:

A. Assign consecutive sequential numbers from 1 to M to each RELEVANT item, where M is the total number of relevant items sampled.

B. Select a random two-digit number between 1 and M from a random number table and eliminate the corresponding item. Where a random number corresponds to an item already deleted, select another random number.

C. Repeat this process until the remaining number reaches 60 or 40. This remaining intermediate high or low sample is reviewed in its entirety for the factor.

11410.1 Methods for Pulling Samples.—One of the considerations of a sampling plan is the adequacy with which the sample reflects the universe from which it is drawn. Therefore, of prime importance in any of the sampling techniques is that each item has the same probability of selection. In the event that problems in sampling arise, this consideration is foremost. Samples are drawn by, or under, the direct supervision of RO personnel. This serves a dual purpose. It ensures RO familiarity with State file contents and configurations and contributes toward an appropriately defined sampling frame. Whenever samples are pulled by State or fiscal agent personnel, RO supervision must be adequate to assure that the sampling plan was fully complied with and that no bias was introduced in either pulling the sample or prescreening the sample before submitting it to the ROs.

In States selecting automated samples it is unnecessary to reverify the validity of the established sampling procedure for each selection, provided the RO has made prior onsite validations of the methodology. This onsite validation includes reviews of software documentation, file structures, and logistical and statistical procedures as well as a careful review of initial sample outputs. Time frames and procedures for transferring automated sample outputs to the RO must be coordinated to ensure that the samples are received timely. Note that any changes to the established automated sampling methodology require a new RO validation.

A. Random Numbers.—The sampling frame (universe) is either represented by a list of some sort or small enough to obviate a list. A list must be complete and nonduplicative. On this list each unit can be assigned a serial number between 1 and the frame (universe) size. To select the sample use random numbers. Random numbers are taken from books specifically published for this purpose or are computer generated. If the sample size is n, pick n random numbers between 1 and the frame (universe) size. If any random numbers picked are duplicative, pick substitutes.

If using the random number tables, mark off sets of columns according to the frame (universe) size. For example, if the universe size is 4268, mark off sets of columns which are four digits wide. Use only those numbers between 1 and 4268 to pick the sample.

To ensure randomness when using a book of random numbers, open the book to a "random" page. Place a pencil down to determine the working page to be used; i.e., the number upon which the pencil lands is the page number to use in selecting the random numbers. Then pick another random number for the column and still another for the row. Go to the working page, column and row and pick random numbers from that point

B. Systematic Random Sample.—The frame (universe) size must be known, or closely estimated. Calculate a skip interval by dividing the frame (universe) size by the sample size and taking the integer portion of this quotient as the skip interval K. Use random numbers to find a starting point m between 1 and K, inclusive. Draw this mth unit and every Kth unit thereafter.

Example: Universe = 140
Sample size = 50 (expanded sampling)
Ratio = 2.8
K = 2

Random start number (from a table of random numbers) = 2

Pick the second item in the universe, then the fourth, the sixth, etc., until the end of the universe is reached (do not stop after the sample size is reached). This could result in an oversample of up to half the desired sample size. The largest oversample occurs when the skip interval is small and the decimal portion which is truncated is greater than .5. If an oversample occurs, randomly select out the number of excess items to reduce the sample to the desired size.

Use either the random number or skip interval method. However, the first method requires a knowledge of the exact frame (universe) size while the skip interval may be used with a good estimate of the frame size. HCFA uses the term frame (universe) because in some cases the frame will not be the "universe" to which we are estimating. For example, in the mailroom sample, the frame is 1 day's receipts, while the universe is the year's receipts.

Where the sampling size is not known or cannot be accurately predicted, it is recommended that the reviewer oversample to the extent necessary to ensure the minimum sample is selected. To accomplish this, use the smallest universe size estimate that could reasonably be expected. This will result in a conservatively small skip interval. If this procedure results in excessive sampling, the sampling excess may be randomly deleted. This oversampling procedure minimizes the risk of potentially costly supplemental samples due to sampling shortages.

C. Measurement Method.—If the physical dimensions of the items sampled are fairly uniform, the systematic (skip interval) sample method may be used in another way. An example is a file drawer of index cards, one per "case," of uniform thickness. If a sample size of 42 is needed and the universe is 90 inches long, we would have a skip interval of 2.1 inches. (It is not necessary to round off because an inch is a continuous measure.) The random start is a two digit number between 1 and 21, inclusive. After selecting the random number, apply the decimal point; e.g., if the number 07 is selected, the starting point is 0.7 inches from the front. This method is not acceptable where the physical dimensions tend to vary.

D. Cluster Sampling.—Some frames or universes are naturally clustered. For example, claims or correspondence may be in file cabinets. If a sample size of 20 is needed, 20 file drawers may be selected at random and one claim or whatever may be pulled randomly from each drawer. Such a procedure may be used with mail bags, stacks of items, etc. However, each item must have an approximately equal chance of selection. Therefore, if some "clusters" have more items than others, use some method to "equalize" the probabilities of selection.

For example, a sample of 20 claims is pulled from a sampling frame of 30 mailbags; the 30 mailbags represent 30 individual clusters. Twenty-eight (28) of the mailbags are half full and the remaining two (2) are completely full. To equalize the clusters you would take one half (1/2) of the claims from each of the two (2) full bags and separate them into 30 equal parts. Then one part would go in each of the 30 mailbags. (It is not necessary to count every item in the mailbags, approximations of volume are acceptable.) Randomly select 20 mailbags (with replacement) and take one (1) claim from each bag selected. When selecting from the bag, vary the place of selection within the bag.

E. Stratified Sampling.—This method can be used when the universe sampled can be logically separated into two (2) or more homogeneous groups or strata. The size of the universe and the individual stratum within the universe must be known. After determining how many items to sample from the universe, determine how many to select from each stratum. The sample selection from each stratum must be proportionate to the total sample as the stratum is proportionate to the universe. The selection within each stratum must be random.

For example, a sample is drawn of adjudicated claims stratified according to the dollar value of program expenditure by type of service. The total program dollar expenditure for all claims in the universe is $10,000.00. The dollar value by type of service is as follows: Inpatient care $5000.00, Physicians Services $2500.00, Outpatient Care $1500.00, Pharmacy $1000.00. Using the dollar values as a basis of stratification the sample proportion is calculated as follows: Inpatient Care $5000/$10,000 or 50 percent of the total sample, Physician Services $2500/$10,000 or 25 percent of the total sample, Outpatient Care $1500/$10,000 or 15 percent of the total sample and Pharmacy $1000/$10,000 or 10 percent of the total sample. Therefore, for this example to pull a stratified sample of 80 claims, 40 must come from Inpatient Care, 20 must come from Physician Services, 12 must come from Outpatient Care, and eight (8) must come from Pharmacy.

Whenever a stratified sample is used, the sampling plan must be submitted to central office for prior approval. This is to ensure uniformity of approach by all regions.

F. Limited Scope Samples.—In a limited scope sample, the material available for sampling on any given day represents the State's operation for only that day or a small number of days. Such a sample would not be regarded as valid from either the State or the Federal point of view. The probability of an error in judgment regarding State performance would be high. In order to obtain reliable results in such cases, two samples a year are necessary. These samples are taken at intervals as widely spaced as is practical.

In order to determine the total sample size for the year, estimate the universe size for the year under review. The year's sample size is in Chart A under the appropriate sampling plan in the same line as the projected universe size. Use this method only when prescribed within a MOE.

1. Methodology for Limited Scope Samples.—In pulling two (2) samples a year, the optimum plan involves two (2) different days of the week and no bias as to the part of the month visited. In addition, avoid both pulls during the same month.

The following are examples of limited scope sampling plans.

Example 1 Expanded Sample:

visit 1: Tuesday	Early November - 40 items
visit 2: Friday	Mid-February - 40 items

Example 2 Normal Sample:

visit 1: Monday	Late October - 10 items
visit 2: Wednesday	Anytime in March - 10

Pull one-half (1/2) of the sample size necessary for the year each time and use valid sampling techniques to select samples. As a reminder, it may be possible in some cases to obtain material necessary for followup evaluation by mail, or it may be desirable to obtain this material at the time of the next sample.

G. Sampling Claims in the Mailroom.—In selecting samples from the State agency mailroom to test certain claims processing factors, some problems are created by any or all of the following: receipt of mail in multiple locations, multiple deliveries, Medicaid mail combined with other State agency mail or Medicaid claims mixed with general Medicaid correspondence, or mail not opened before distribution to the various Medicaid departments or returning mail to normal workflow.

As these situations are addressed, the basic premise in any method of sample selection is that each item should have the same probability of selection. Following are some suggestions. Other approaches are acceptable as long as the method chosen is practical and promotes the selection of an unbiased sample.

1. Multiple Deliveries In One Day.—If there are several deliveries during the day, do not retain the incoming mail in the mailroom until after the sample is selected. Since limited scope sampling will be used and the number of visits to select the sample is two (2), vary the times of each review so that each is made at a different time of day; i.e., early morning, mid-morning, late morning or afternoon.

2. Multiple Locations for Receipt of Mail.—Determine in advance all possible locations where mail is received routinely and includes all items from each location in the sampling frame. These items may be selected by using a skip interval based on the estimated volume of claims in all locations.

3. Medicaid Mail Combined With Other State Agency Mail or Medicaid Mail Contains Both Claims and Correspondence.—Select the sample after the initial sort into Medicaid and non-Medicaid mail or into Medicaid claims and correspondence. If an item is selected which does not belong in the sample, disregard it and select the previous or following item.

4. Mail Not Opened Before Distribution to Medicaid Components.—Although it is not necessary for the State to open and date stamp mail at the point of receipt, the State's procedures should require that the actual date of receipt is used to age the claim. If mail is not opened in the State agency mailroom, select the sample from unopened mail, open the envelope, photocopy the claim, then replace the item in the envelope, and return it to the point of selection for normal processing.

5. Returning Mail to the Normal Work Flow.—Take every precaution to maintain the integrity of the sample. Return claims sampled in the mailroom to the normal work flow in such a manner that they cannot be identified subsequently as items which are part of the SPR sample. For example, sampling from mail not opened before distribution as previously explained could create a problem. If the only envelopes opened when the Medicaid component receives the day's receipts are the items sampled for the SPR, this could bias the handling of these claims and thus violate the integrity of the sample.

11410.2 Sample Sizes Chart

Universe Size	Expanded Sampling	Intermediate High Sampling	Intermediate Low Sampling	Normal Sampling
1 - 8	All	All	All	All
9 - 25	All	All/20	All/20	8
26 - 40	25	24	20	8
41 - 60	30	30	24	8
61 - 90	40	36	27	8
91 - 150	50	43	31	8
151 - 250	60	48	34	8
251 - 600	70	54	37	8
601 - 3200	80	60	40	13
3201 or more	80	60	40	20

In addition to the above sample sizes, element 4G requires a fixed sample of 180.

11415. SYSTEM PERFORMANCE REVIEW (SPR) SCORING METHODOLOGY - GENERAL

Passing a standard requires a minimum number of points depending on the number of elements within each standard. Those point levels are:

1 element - 44 points
2 elements - 88 points (no element score less than 38)
3 elements - 132 points (no element score less than 38, and 2 out of 3 having a score of 44 or more)

To determine if the standard has been met, simply sum the final element scores for that standard. Note that passing every element is not required for passing a standard, except where a standard has but one element. For a three element standard, two of the elements must be passed to pass the entire standard. It was necessary to create a "floor" (38 points) for performance at the element level to ensure an extremely low score in one element could not be compensated for through the bonus points of another element. Seventy-five (75) percent enhanced Federal funding requires all system functions to meet minimum requirements.

Penalty points are assessed to each factor in which a State fails to meet minimum levels of acceptable performance. To determine the actual penalty amount for a factor, multiply the penalty point(s) times the factor weight.

Bonus points are assessed to each factor in which a State demonstrates superior achievement. To determine the actual bonus amount for a factor, multiply the bonus point(s) times the factor weight. Bonus points are awarded only after it has been determined that the element score is passing.

The starting score for an element is 50. The passing score for an element is 44. To compute the initial score, subtract the sum of the actual penalty amounts (penalty point(s) X factor weights) for an element from the starting score. If the initial score equals or exceeds the passing score (44), then the sum of the actual bonus amounts can be added to obtain the final score. If the initial score is 43 or less, the initial score becomes the final score and actual bonus amounts assessed cannot be awarded. (See §11415.1B for additional instructions on the treatment of penalty and bonus points.)

The scoring for each factor depends upon whether sampling, some other form of numerical scoring, or a non-statistical type of evaluation is involved. The factor scoring mechanisms are explained in general terms below. Each factor in the element will spell out the type of scoring and weights used for that factor and any exceptions. In all cases, where a factor is "deemed met" (i.e., no true evaluation occurs) no penalty accrues, nor are bonus points awarded.

A "deemed met" situation occurs when a function intended for review is not performed, and not performing it is correct. For example, Factor 1B1 is intended to measure buy-in updates. Obviously, States who do not buy-in to Medicare would be "deemed met" because the function does not exist within the State's system. In these obvious situations "deemed met" can be awarded without consultation, but in all other situations ROs must first consult with the Bureau of Quality Control before a "deemed met" factor score can be awarded. If a function intended for review is not performed, and not performing it is incorrect, maximum penalties are assessed according to the factor scoring methodology. Because all evaluations are based on performance from the beginning of the period until the date of the review, scoring should be based on the entire period of the review, even if the State did not perform the relevant functions for that entire period. Moreover, where reports, profiles, or similar items are being reviewed, all such items or their demonstrable conceptual equivalents, even if not produced, must be included in the universe for sample selection. For example, if reports A, B, and C are required to be produced each quarter but are produced only in the fourth quarter, the universe for sample selection would be 12 (three reports multiplied by four quarters). If a report selected in the sample was not produced, maximum penalty points would be assessed.

11415.1 Methods for Scoring.—The instructions in this section and in the preceding §11415 are followed for scoring the SPR.

A. Factor Scoring.—Scoring, unless otherwise specified in the factor instructions is done according to Charts A-F. Chart A gives the score (bonus or penalty points) awarded based on the percentage of items correct in a fixed or expanded sample. Chart B gives the score awarded based on the percentage of items correct in an intermediate high sample. Chart C gives the score awarded based on the percentage correct in an intermediate low sample. Chart D gives the score awarded based upon the number of items incorrect in a normal sample. Chart E yields the score according to the percentage of items correct when an entire universe of 26 items or more is reviewed. Chart F provides for scoring universes of 25 items or less.

The charts have built-in tolerances to account for uncertainty resulting from sampling. This is true also for charts used for universe scoring because the universes being examined are not always the true universes and are subject to some degree of uncertainty. When a factor has a specific Acceptable Performance Level (APL), this APL represents a range of performance for any given bonus/penalty point. For example, using expanded sample Chart A1 and a 90 percent APL to get two (2) bonus points, the actual performance could be anywhere within the range of 95.1 percent to 100 percent. To get two (2) penalty points, actual performance for a 90 percent APL could range from 78.1 percent to 81.2 percent.

When a factor calls for special scoring, usually in assessing administrative procedures, make a determination based on review findings and assign points as follows:

Significantly exceeds requirements = 1 bonus point x weight

Meets requirements = 0 points

Minor problems = 1 penalty point x weight

Uncorrected minor problems from previous review = 2 penalty points x weight

Major problems = 3 penalty points x weight

Uncorrected major problems from the immediately preceding review = 4 penalty points x weight

Defined scoring instructions are shown (defined) in the method of evaluation of individual factors, where the other scoring methods above do not apply or where they have been modified to more accurately evaluate performance.

B. Treatment of Decimals

1. Percentages.—Where performance is computed as a percentage, round the percentage correct in the sample or universe to one decimal place. Round up if the second decimal place is 5 or above; e.g., 95.46 = 95.5 and 93.24 = 93.2.

2. Penalty and Bonus Points.—In computing penalty and bonus points, round up if the decimal is 5 or above. Compute penalty points for each factor in the element, multiply by the weight, and round to one decimal place. Total all penalty points for the element, subtract from the starting score of 50, then round to the nearest whole number to give the initial score. Compute bonus points for each factor, multiply by the weight, and round to one decimal place. If the initial socre is 44 or above, total all bonus points for the element, add to the initial score, and round to the nearest whole number to obtain the final score. If the initial score falls between 43.5 and 43.9, round up to 44 and award bonus points.

Worksheets are provided following Standard 7 which provide all necessary information to score State performance (see Appendix A). It will be necessary only to fill in the blanks to derive element scores. These scores will then be summed to determine if the individual standards have been met.

C. Examples of Factor Scoring

1. Expanded Sample Scoring

Acceptable Performance Level = 90%
Weight = 2
Universe size = 10,000
Sample size = 80

a. Using scoring chart A1, if the percentage correct in the sample is 83.5 - 90.0 the factor is passed. There are no penalty or bonus points.

b. If the percentage correct in the sample is less than 83.5, obtain penalty points from scoring chart A1. Thus, if the score were 79%, assess 2 penalty points times the weight (2): 2 x 2 = 4 actual penalty amount.

c. If the percentage correct in the sample is greater than 90, obtain bonus points from scoring chart A1. Thus, if the score were 95%, you would award 1 bonus point times the weight (2): 1 x 2 = 2 actual bonus amount. (Bonus points are awarded only if the element as a whole is passed.)

2. Fixed Sample Scoring

Acceptable Performance Level = 99%
Weight = 3
Universe Size = NA
Sample Size = 180

a. Using scoring chart A2, if the percentage correct in the sample is 97.5 - 100 the factor is passed. There are no penalty or bonus points.

b. If the percentage correct in the sample is less than 97.5, obtain the penalty points from scoring chart A2. Thus, if the score were 95%, assess 3 penalty points times the weight (3): 3 x 3 = 9 actual penalty amount.

c. Since the APL is 99%, no bonus points are available in scoring chart A2 for this example.

3. Intermediate High Sample Scoring

Acceptable Performance Level = 97.5%
Weight = 1
Universe Size = 10,000
Sample Size = 60

a. Using scoring chart B, if the percentage correct is 93.0 - 96.5 the factor is passed. There are no penalty or bonus ponts.

b. If the percentage correct in the sample is less than 93.0, obtain penalty points from scoring chart B. Thus, if the score were 88.0%, assess 3 penalty points times the weight (1): 3 x 1 = 3 actual penalty amount.

c. If the percentage correct in the sample is greater than 96.5, obtain bonus points from scoring chart B. Thus, if the score were 97.0%, you would award 1 bonus point times the weight (1): 1 x 1 = 1 actual bonus amount. (Bonus points are awarded only if the element as a whole is passed.)

4. Intermediate Low Sample Scoring

Acceptable Performance Level = 90%
Weight = 2
Universe Size = 5,000
Sample Size = 40

a. Using scoring chart C, if the percentage correct is 80.8 - 87.5 the factor is passed. There are no penalty or bonus points.

b. If the percentage correct in the sample is less than 80.8, obtain penalty points from chart C. Thus, if the score were 72.5%, assess 3 penalty points times the weight (2): 3 x 2 = 6 actual penalty amount.

c. If the percentage correct in the sample is greater than 87.5, obtain bonus points from scoring chart C. Thus, if the score were 94.2%, you would award 2 bonus points times the weight (2): 2 x 2 = 4 actual bonus amount. (Bonus points are awarded only if the element as a whole is passed.)

5. Normal Sample Scoring

Acceptable Performance Level = 90%
Weight = 2
Universe size = 10,000
Sample size = 20

a. Using scoring chart D, if the number wrong in the sample is 4-6, the factor is passed. There are no penalty or bonus points.

b. If the number wrong in the sample is greater than 6, obtain the penalty points from scoring chart D. Thus, if the number of errors were 10 there are 4 penalty points times the weight (2) for an actual penalty amount of 8.

c. If the number wrong in the sample is less than 4, obtain the bonus points from scoring chart D. Thus, if the number wrong is 2, award 1 x 2 = 2 actual bonus amount. (Note, again, that bonus points are awarded only if the element is passed.)

6. Universe Scoring

Acceptable Performance Level = 75% (based on total data, not sample data)
Weight = 2

a. Using scoring chart E, if the State scores 72.6 - 77.5%, factor is passed. There are no penalty or bonus points.

b. If the State scores less than 72.6% obtain penalty from scoring chart E. Thus if the score were 70%, assess 2 penalty points times the weight (2): 2 x 2 = 4 actual penalty amount.

c. If the State scores higher than 77.5% obtain the bonus points from scoring chart E. Thus, if the score were 80%, you would award 1 bonus point times the weight (2): 1 x 2 = 2 actual bonus amount (if the element is passed).

7. Special Scoring

Weight = 2

a. If the State's performance is determined to be acceptable, the score is 0.

b. If performance is judged to need minor improvement, assess one penalty point times the weight: 1 x 2 = 2 actual penalty amount.

c. If performance reveals that minor problems from previous reviews remain uncorrected (and are well documented), assess (2) two penalty points times the weight: 2 x 2 = 4 actual penalty amount.

d. If performance is judged to be an outright failure or the activity to be reviewed is not performed at all, assess three (3) penalty points times the weight: 3 x 2 = 6 actual penalty amount.

e. If the review reveals major problems from the immediately preceding review which remain uncorrected (and are well documented), assess four (4) penalty points times the weight: 4 x 2 = 8 actual penalty amount.

f. If performance is significantly above basic requirements, award one (1) bonus point times the weight: 1 x 2 = 2 actual bonus amount.

8. Defined Scoring.—For some factors the methods of evaluation require unique scoring mechanisms. The penalty and bonus point calculations are spelled out for each of these factors.

9. Stratified Sample Scoring.—The overall score for factors using stratified sampling is the composite of the weighted scores for each strata.

a. Compute the percentage of claims without error for each strata.

b. Compute the weight for each strata by dividing the number of claims (or dollars) in the strata by the number of claims in the universe. Use dollar weighting for dollar error rate calculations and claim weighting for all other calculations.

c. Multiply the percentage correct by the weight for each strata and sum the products. The result is the performance for the factor. Use the appropriate weight and scoring chart for the factor to determine the final score.

d. To score element 3F the claims data must be sorted into two groups; one being clean practitioners (CP) and the other, non-clean practioner (NC) and nonpractitioner (NP). Each group is then sorted into the three strata. The percentage of claims processed timely is then determined for each stratum. The weight for each stratum is then determined by dividing the universe for each stratum by the total universe. If there are no claims for a given stratum in the group, the universe for that stratum is not included in the total universe. The percent timely in each stratum is multiplied by the stratum weight and the products are summed yielding the weighted percent timely. The factor score is that found using the appropriate scoring chart. For stratified sampling only, use the entire sampling frame without sampling down. Use the scoring chart which applies to a sample size equal to or less than the sample.

EXAMPLE

CLEAN PRACTITIONER CLAIMS

Strata	Universe	Adjudicated Claims Sample	# Claims	Claims Paid Within <= 30 Days	Claims Paid Within <= 90 Days	Claims Paid Within <= 365 Days
1	46,000	30	28	93.1%	100%	100%
2	1,000	90	0	---		---
3	53,000	60	53	88.7%	100%	100%
	100,000	180	81			

Strata	Weight	<= 30 Days	<= 90 Days	<= 365 Days
1	46/99 = .46465	43.259%	46.5%	46.5%
2	0			
3	53/99 = .53535	47.486%	53.5%	53.5%
	1.00000	90.745%	100.0%	100.0%

Non-Clean Practitioners and Non Practitioners

Strata	# Claims	Paid Within <= 30 Days	Paid Within <= 365 Days	Weight	Weighted Timeliness <= 30 Days	Weighted Timeliness <= 365 Days
1	2	100.0%	100%	46/100 = .46	46.0%	46%
2	90	92.2%	100%	1/100 = .01	9.2%	1%
3	7	66.6%	100%	53/100 = .53	35.3%	53%
	99			1.00	90.5%	100%

11415.2 Expanded/Fixed Sampling Scoring - Chart A

A1 - Expanded Sample Scoring

Bonus/Penalty Pts. \ APL	99%	97.5%	95%	90%	85%
	Percentage Points				
+2	-	-	-	95.1 - 100.0	92.6 - 100.0
+1	-	97.6 - 100.0	95.1 - 100.0	90.1 - 95.0	85.1 - 92.5
0	97.1 - 100.0	93.6 - 97.5	90.1 - 95.0	83.5 - 90.0	77.1 - 85.0
-1	95.7 - 97.0	92.3 - 93.5	88.1 - 90.0	81.3 - 83.4	75.1 - 77.0
-2	94.4 - 95.6	91.0 - 92.2	86.1 - 88.0	78.1 - 81.2	73.1 - 75.0
-3	93.1 - 94.3	89.7 - 90.9	84.1 - 86.0	76.1 - 78.0	71.9 - 73.0
-4	91.8 - 93.0	88.4 - 89.6	82.1 - 84.0	74.1 - 76.0	69.1 - 71.8
Penalty Formula for 5 or more Penalty Pts.	$\frac{1}{2}$(100.0 - PERF)	$\frac{1}{2}$(97.5 - PERF)	$\frac{1}{2}$(92.0 - PERF)	$\frac{1}{2}$(84.0 - PERF)	$\frac{1}{2}$(79.0 - PERF)

A2 - Fixed Sample Scoring

Bonus/Penalty Pts. \ APL	99%	97.5%	90%
+2	-	-	95.1 - 100.0
+1	-	97.6 - 100.0	90.1 - 95.0
0	97.5 - 100.0	95.1 - 97.5	85.5 - 90.0
-1	96.3 - 97.4	93.8 - 95.0	83.0 - 85.4
-2	95.2 - 96.2	92.6 - 93.7	80.8 - 82.9
-3	94.1 - 95.1	91.4 - 92.5	78.6 - 80.7
-4	93.0 - 94.0	90.2 - 91.3	76.4 - 78.5
Penalty Formula for 5 or more Penalty Pts.	.75(99.6 - PERF)	.65(97.8 - PERF)	.5(86.3 - PERF)

NOTE: Bonus or penalty points must be multiplied by weight of the factor. For treatment of decimals, see section 11415.1B

11415.3 Intermediate High Sample Scoring - Chart B

	Minimum Sample Size 20	Maximum Sample Size 60	
	99%	97.5%	90%
2 Bonus	-	-	94.6 - 100.0
1 Bonus	-	96.6 - 100.0	89.1 - 94.5
0	96.5 - 100.0	93.0 - 96.5	82.5 - 89.0
1 Penalty	94.5 - 96.4	91.3 - 92.9	79.9 - 82.4
2 Penalty	92.5 - 94.4	89.6 - 91.2	77.3 - 79.8
3 Penalty	90.5 - 92.4	87.9 - 89.5	74.7 - 77.2
4 Penalty	88.5 - 90.4	86.2 - 87.8	72.1 - 74.6
Penalty Formula for 5 or more Penalty Points	1/2 (99.0 - PERF)	1/2 (97.5 - PERF)	1/2 (82.0 - PERF)

11415.4 Intermediate Low Sample Scoring - Chart C

	Minimum Sample Size 20	Maximum Sample Size 40	
	99%	97.5%	90%
2 Bonus	-	-	93.8 - 100.0
1 Bonus	-	96.1 - 100.0	87.6 - 93.7
0	96.0 - 100.0	92.7 - 96.0	80.8 - 87.5
1 Penalty	93.8 - 95.9	90.8 - 92.6	77.9 - 80.7
2 Penalty	91.6 - 93.7	88.9 - 90.7	75.0 - 77.8
3 Penalty	89.4 - 91.5	87.0 - 88.8	72.1 - 74.9
4 Penalty	87.2 - 89.3	85.1 - 86.9	69.2 - 72.0
Penalty Formula for 5 or more Penalty Points	1/2 (97.0 - PERF)	1/2 (95.0 - PERF)	1/2 (80.0 - PERF)

NOTE: Bonus or penalty points must be multiplied by the weight of the factor. For treatment of decimals, see section 11415.1B

11415.5 Normal Sampling Scoring - Chart D

85% APL

Sample Size \ Bonus/Penalty Points	+1	0	-1	-2	-3	-4 or over
			ERRORS			
8	0-1	2-3	4	5	6	
9	0-1	2-4	5	6	7	
10	0-1	2-4	5	6	7	
11	0-2	3-5	6	7	8	
12	0-2	3-5	6	7	8	One additional penalty point for each additional error over -3 level
13	0-2	3-5	6	7	8	
14	0-2	3-6	7	8	9	
15	0-2	3-6	7	8	9	
16	0-2	3-6	7	8	9	
17	0-3	4-7	8	9	10	
18	0-3	4-7	8	9	10	
19	0-3	4-8	9	10	11	
20	0-3	4-8	9	10	11	
21	0-3	4-8	9	10	11	

90% APL

Sample Size \ Bonus/Penalty Points	+1	0	-1	-2	-3	-4 or over
			ERRORS			
8	0	1-3	4	5	6	
9	0	1-3	4	5	6	
10	0	1-3	4	5	6	
11	0-1	2-4	5	6	7	
12	0-1	2-4	5	6	7	One additional penalty point for each additional error over -3 level
13	0-1	2-4	5	6	7	
14	0-1	2-4	5	6	7	
15	0-1	2-4	5	6	7	
16	0-1	2-4	5	6	7	
17	0-3	3-5	6	7	8	
18	0-3	4-6	7	8	9	
19	0-3	4-6	7	8	9	
20	0-3	4-6	7	8	9	
21	0-3	4-6	7	8	9	

Note: Bonus or penalty points must be multiplied by the weight of the factor.

Normal Sampling Scoring - Chart D (Continued)

95% APL or 97.5% APL

Sample Size \ Bonus/Penalty Point	+1	0	-1	-2	-3	-4 or over
			ERRORS			
8	0	1-2	3	4	5	
9	0	1-2	3	4	5	
10	0	1-2	3	4	5	
11	0-1	2-3	4	5	6	
12	0-1	2-3	4	5	6	One additional
13	0-1	2-3	4	5	6	penalty point
14	0-1	2-3	4	5	6	for each
15	0-1	2-3	4	5	6	additional
16	0-1	2-3	4	5	6	error over -3
17	0-1	2-4	5	6	7	level
18	0-1	2-4	5	6	7	
19	0-1	2-4	5	6	7	
20	0-1	2-4	5	6	7	
21	0-1	2-4	5	6	7	

99% APL
(No Bonus Points)

Sample Size \ Penalty Points	0	-1	-2	-3	-4 or over
			ERRORS		
8	0-1	2	3	4	
9	0-1	2	3	4	
10	0-1	2	3	4	
11	0-2	3	4	5	
12	0-2	3	4	5	
13	0-2	3	4	5	One additional penalty
14	0-2	3	4	5	point for each additional
15	0-2	3	4	5	error over -3 level
16	0-2	3	4	5	
17	0-3	4	5	6	
18	0-3	4	5	6	
19	0-3	4	5	6	
20	0-3	4	5	6	
21	0-3	4	5	6	

Note: Bonus or penalty points must be multiplied by the weight of the factor.

11415.6 Universe Scoring - Chart E

Bonus/ Penalty Pts. \ APL	99.5%	99%	97.5%	95%
	Percentage Correct			
+2	-	-	-	-
+1	-	-	98.6 - 100.0	96.1 - 100.0
0	98.6 - 100.0	98.1 - 100.0	96.6 - 98.5	94.1 - 96.0
-1	97.6 - 98.5	97.1 - 98.0	95.6 - 96.5	92.7 - 94.0
-2	96.6 - 97.5	96.1 - 97.0	94.6 - 95.5	91.3 - 92.6
-3	95.6 - 96.5	95.1 - 96.0	93.6 - 94.5	89.9 - 91.2
-4	94.6 - 95.5	94.1 - 95.0	92.6 - 93.5	88.5 - 89.8
Formula for 5 or more Penalty Pts.	(99.5 - PERF)	(99.0 - PERF)	(97.5 - PERF)	0.7(95.5 - PERF)

Bonus/ Penalty Pts. \ APL	90%	82%	75%	50%
	Percentage Correct			
+2	95.6 - 100.0	92.1 - 100.0	90.1 - 100.0	80.1 - 100.0
+1	91.6 - 95.5	84.1 - 92.0	77.6 - 90.0	55.1 - 80.0
0	88.6 - 91.5	80.1 - 84.0	72.6 - 77.5	45.1 - 55.0
-1	87.1 - 88.5	78.1 - 80.0	70.1 - 72.5	40.1 - 45.0
-2	86.6 - 87.0	76.1 - 78.0	67.6 - 70.0	35.1 - 40.0
-3	85.1 - 86.5	74.1 - 76.0	65.1 - 67.5	30.1 - 35.0
-4	83.6 - 85.0	72.1 - 74.0	62.6 - 65.0	25.1 - 30.0
Formula for 5 or more Penalty Pts.	$\frac{2}{3}$(91.0 - PERF)	$\frac{1}{2}$(82.0 - PERF)	0.4(75.0 - PERF)	$\frac{1}{5}$(50.0 - PERF)

NOTE: Bonus or Penalty points must be multiplied by the weight of the factor. For treatment of decimals, see section 11415.1B.

11415.7 Small Universe Scoring - Chart F

Bonus/Penalty Points / Universe	+2	+1	0	-1	-2	-3	-4 or Worse
				ERRORS			
1	-	-	0	1	-	-	
2	-	-	0	1	2	-	
3	-	-	0	1	2	3	
4	-	-	0	1	2	3	
5	-	0	1	2	3	4	
6	-	0	1	2	3	4	One additional penalty point for each additional error over -3 penalty point level
7	-	0	1	2	3	4	
8	-	0	1	2	3	4	
9	-	0	1	2	3	4	
10	-	0	1	2	3	4	
11	-	0	1	2	3	4	
12	-	0	1	2	3	4	
13	0	1	2	3	4	5	
14	0	1	2	3	4	5	
15	0	1	2	3	4	5	
16	0	1	2	3	4	5	
17	0	1	2	3	4	5	
18	0	1	2	3	4	5	
19	0	1	2	3	4	5	
20	0	1	2	3	4	5	
21	0	1	2	3	4	5	
22	0-1	2	3	4	5	6	
23	0-1	2	3	4	5	6	
24	0-1	2	3	4	5	6	
25	0-1	2	3	4	5	6	

NOTE: Bonus or penalty points must be multiplied by the weight of the factor.

11420. SPR PERFORMANCE STANDARDS

The performance standards enumerated in §§11420.1-11420.7 cover the basic requirements of eligibility, support files, orderly, accurate and timely claims processing and review, MARS, S/URS, and general administration. The concept of demonstrable conceptual equivalence is used in assessing State performance and adherence to established system requirements.

11420.1 STANDARD 1 - ELIGIBILITY.—An Accurate System of Recipient Eligibility Information Must Be Provided.

A. Element A.—THE STATE MUST MAKE ACCURATE ELIGIBILITY DETERMINATIONS AND MUST BE RESPONSIVE TO PROVIDER REQUESTS FOR RECIPIENT ELIGIBILITY INFORMATION.

Factor 1A1: The State must integrate federally reported SSI data into the eligibility file timely. This measure is deemed met for non-1634 States.

PERFORMANCE LEVEL: 95 percent of eligibility file updates, deletions, and record changes must be made within ten (10) working days of receipt of State Data Exchange (SDX) transaction tapes.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Review State procedures to determine the frequency and method (mail or Programmable Magnetic Tape Terminal (PMTT)) by which the State receives the federally produced SDX transaction tapes in order to determine the sample universe. (Do not include the monthly treasury tapes.)

2. Select a normal sample from at least six (6) months of SDX transaction tapes. Review State logs to determine the actual dates of receipt of the SDX and the dates the data were input to the eligibility (social services) files.

3. Updates of SSI accretions, deletions, and record changes must be made within ten (10) working days of receipt of the SDX.

4. Use scoring chart D, page 11-4-23.

Factor 1A2: All changes to the main eligibility file (the State eligibility file from which records are extracted or made available to claims processing) must be made available timely for MMIS claims processing use.

PERFORMANCE LEVEL: Claims processing eligibility file changes must be made within ten (10) working days of the main eligibility file update.

Use defined scoring as follows:

a. One (1) bonus point if all tapes are processed within five (5) working days, or if the State MMIS directly accesses the main eligibility file for claims processing purposes.

b. Zero (0) points if all tapes are processed in six (6) to ten (10) working days.

c. One (1) penalty point for every tape processed after the 10th working day.

d. A maximum of six (6) penalty points may be accrued.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Using normal sampling, select a sample of State transaction tapes. If universe is eight (8) or less, the entire universe must be reviewed.

2. The regional office must validate that actual processing dates, rather than system assigned dates, are used.

3. Resultant updates to the claims processing eligibility file from the main eligibility file must be made within ten (10) working days of the update to the main eligibility file. If the main eligibility file is the result of an on-line update, the subsequent update to the claims processing eligibility file must be done at least every ten (10) working days.

Factor 1A3: Medicaid eligibility indicators must be reflected on identification media, or equivalent, in accordance with State policy.

PERFORMANCE LEVEL: State procedures and practice must provide for issuing accurate eligibility identification media or equivalent, in accordance with State policy.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Review the State's policy and procedures for issuing Medicaid eligibility identification media.

2. Determine if the policy and procedures conform to State plans.

3. Review record layouts or facsimile for eligibility identification media and State provided media examples to determine if the policy and procedures are being followed. If the State uses a system which requires verification of eligibility status when the identification media is presented, determine if the data available for response is consistent with the policy and procedures.

4. Determine if third party liability (TPL), lock-in, HMO, or other indicators, are provided for in the media contents in accordance with State policy.

5. Use special scoring, page 11-4-17.

B. Element B.—THE STATE MUST MAINTAIN ACCURATE AND ADEQUATE FILES ON ELIGIBLE RECIPIENTS.

Factor 1B1: If a buy-in State, the buy-in data must be integrated into the main eligibility file or third party file on a timely basis.

PERFORMANCE LEVELS: State buy-in tapes must be processed to update eligibility or third party tapes within 30 days.

Use defined scoring as follows:

a. One (1) bonus point if all tapes were processed within 19 days.

b. Zero (0) points if all tapes were processed within 30 days.

c. One (1) penalty point for every tape not processed within 30 days.

d. A maximum of six (6) penalty points may be accrued.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Review State tape control logs for six (6) monthly buy-in tapes sent to the State by HCFA during the review period.

2. Verify that the tapes were processed to update the appropriate eligibility/third party file.

Factor 1B2: If a buy-in State, the buy-in data must be accurately integrated into the main eligibility file or third party file.

PERFORMANCE LEVEL: 95 percent of buy-in eligibles must contain accurate Medicare Part B coverage indicators.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. Use normal sampling. A sample of buy-in eligibles accreted or deleted within the current review period should be used. This will be provided by central office.

2. Verify that the appropriate eligibility/third party files contain accurate Medicare Part B coverage indicators as reflected in the buy-in sample.

3. Use scoring chart D, page 11-4-23.

Factor 1B3: The State must have procedures in place to solicit TPL information at the time of eligibility determination/redetermination (used to update the State MMIS) as required by approved State Plan, Federal regulations, and State Policy.

PERFORMANCE LEVEL: 95 percent of the eligibility case files must show that the State solicited TPL information at the time of the eligibility determination/redetermination in conformance with approved State Plan, Federal regulations, and State Policy.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Review the State procedures for acquiring TPL information including forms/questionnaires filled out at the time of eligibility determination/redetermination, follow-up procedures to verify information furnished by the recipient, etc. If a 1634 State, verify the existence of an agreement with SSA to collect TPL data.

2. Determine if the information reviewed will allow for the capture of TPL data required in the State Plan, Federal regulations, and State Policy. Where a conflict may exist, review in order of priority against the approved State Plan, Federal regulations, and lastly, State Policy.

3. Select a normal sample of current Medicaid eligibles excluding SSI eligibles. Have the State provide TPL related information from completed case files for each sample recipient.

4. Review the case file to determine if the procedures were followed and issues raised were appropriately pursued.

5. Use scoring chart D, page 11-4-23.

NOTE: This factor is scored and reported for monitoring purposes only in FY 1987. However, if the Federal regulation is published and provides for State implementation, incorporating TPL into the MMIS by March 31, 1987, the factor score will be included as part of the SPR evaluation.

Factor 1B4: The State must accurately and timely integrate third party liability (TPL) data into (transferrable or accessible by or to) the eligibility/third party file.

PERFORMANCE LEVEL: 99 percent of the records on file of the sampled eligibles must contain the required TPL indicators available from the State's eligibility system. The system files must be updated within 30 days of the receipt of verified TPL data.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Review systems documentation to determine how the eligibility reference files/third party files are updated to capture the most recent TPL data.

2. Select an intermediate low sample of Medicaid eligibles with TPL indicators from the State's claims processing eligibility file. Have the State submit documentation of the date of receipt of verified TPL data. If a State does not retain verified TPL data, analyze the procedures to assure that updates will occur within 30 days.

3. Compare sampled items with the TPL information available to the MMIS system to verify that TPL indicators (e.g., workers' compensation coverage, health insurance, personal injury protection insurance, liability insurance for bodily injury damages, policy information, or other positive TPL responsibility) are processed.

4. Determine if the date the claims processing file is updated is within 30 days of the receipt of verified TPL data.

5. Use scoring chart C, page 11-4-21. If the verified TPL data can not be obtained and procedures checked do not support that data can be integrated within 30 days, add an additional penalty point to the score.

NOTE: This factor is scored and reported for monitoring purposes only in FY 1987. However, if the Federal regulation is published and provides for State implementation, incorporating TPL into the MMIS by March 31, 1987, the factor score will be included as part of the SPR evaluation.

Factor 1B5: The State must actively obtain and match data from public and private sources to identify third parties who may be liable for care and services provided under Medicaid. The data must be integrated into the eligibility/third party file.

PERFORMANCE LEVEL: Data matches required by Federal regulations must be performed and the data match lists must be integrated into the files.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Review the records of the State which indicate the data matches performed. Also, review the State's correspondence which documents the attempts made to perform matches with other entities.

2. Determine if a good faith effort has been made to comply with Federal regulations (e.g., no data matches but documents indicate matches proposed to those entities, at a minimum, as called for in the regulations).

3. Allow the State to demonstrate that positive, verified results, as a result of data matches, have been integrated into the files. For example, review computer-run data and/or records of files changed.

4. Use special scoring, page 11-4-17.

NOTE: This factor is scored and reported for monitoring purposes only in FY 1987. However, if the Federal regulation is published and provides for State implementation, incorporating TPL into the MMIS by March 31, 1987, the factor score will be included as part of the SPR evaluation.

THIS PAGE TO BE LEFT BLANK

11420.2 STANDARD 2 - SUPPORT FILES.—An Accurate and Accessible System of Files Must Be Provided to Support System Operations

A. ELEMENT C.—ACCURATE AND ADEQUATE FILES MUST BE MAINTAINED ON ELIGIBLE PROVIDERS.

Factor 2C1: The provider eligibility file must be accurate and updated timely with provider status changes.

PERFORMANCE LEVEL: 99 percent of provider status changes should be posted within ten (10) working days.

WEIGHT: 1.5

METHOD OF EVALUATION:

1. Use normal sampling. Select a sample of those providers that were added, deleted, or had a status change during the review period. Status changes are those changes to the provider file that affect a provider's (1) entitlement to payment, (2) amount eligible to be paid, (3) services for which payment can be made, and (4) mode of practice; i.e., solo, group, clinic, etc. Address changes and State-initiated file clean-up will not be evaluated. Note: For States which employ separate provider status and provider rate files, limit the scope of the sample to changes to the provider status file.

2. Determine the dates the status changes were approved, as defined by written State policy. Changes which do not require specific approval under State procedures are measured from the date of receipt by the State.

3. Check the date the provider's enrollment, update or disenrollment transaction was posted to the claims processing system. Changes should be posted within ten (10) working days of receipt or approval if specific approval is required.

4. Count no more than one (1) error per provider.

5. Use scoring chart D, page 11-4-23.

Factor 2C2: A unique identifier must be provided for each enrolled provider to permit all services rendered to be adequately tracked.

PERFORMANCE LEVEL: 99 percent of active individual non-institutional providers must be assigned a unique identifier.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. Select a normal sample of active individual non-institutional providers.

2. Check the sample against the latest Alphabetic Provider Listing for duplicate names which have two (2) numbers that are not cross-referenced. If this cannot be accomplished using only the alpha listing, check the sample against the Provider Listing by Group Affiliation.

3. Where duplicates are found, verify that no more than one (1) unique identifier was assigned per provider type. However, unique identifiers which can be determined to be modifiers (such as billing address keys or cross-reference numbers) are acceptable and are not to be considered duplicates. Providers that submit teaching hospital claims or only Medicare crossover claims may have duplicate identifiers; however, they should not be counted as errors.

4. Use scoring chart D, page 11-4-23.

Factor 2C3: Providers which practice in group settings must be assigned individual rendering provider numbers (in addition to any group practice number). The automated system must collect all claims experience under the individual unique identifier for monitoring charges and payments and S/URS operations. This factor is deemed met in States which do not recognize groups as either providers, billers, or payees.

PERFORMANCE LEVEL: 99 percent of all group practices must be assigned individual unique identifiers.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Obtain a listing of all group practices as defined by the State, and select a normal sample.

2. Obtain a provider payment history for each of the selected groups. From the payment history randomly select a claim paid within the review period. If no claims were paid return to the group listing to select another group. Repeat this process until a normal sample of claims paid to groups is selected. If there is another source from which to sample claims paid to groups it may be used.

3. Verify that each claim paid to a group also carried an individual rendering provider number and that this number (in addition to the group number) is recorded in the system for the S/URS operation. Providers that submit teaching hospital claims or only Medicare crossover claims may have duplicate identifiers; however, they should not be counted as errors.

4. Use scoring chart D, page 11-4-23.

D. ELEMENT D.—ACCURATE PRICING FILES MUST BE MAINTAINED FOR READY ACCESS IN SYSTEM OPERATIONS.

Factor 2D1: Pricing file transactions must be posted timely.

PERFORMANCE LEVEL: 95 percent of pricing file changes must be made prior to the effective date or within ten (10) working days after final approval or receipt, as appropriate.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. Review the State's written procedures for updating the pricing file to determine the approval process for changes.

2. Select a normal sample of pricing file updates. Pharmacy pricing collective updates from sources outside the State Medicaid Agency; e.g., Red Book, Blue Book, using one (1) medium (tape, disc, etc.) are counted as one (1) update. For States which employ separate provider status and provider rate files, include in the universe pricing file updates to the provider rate/pricing file.

3. Changes to the pricing file must be made prior to the effective date, or within ten (10) working days after final approval or receipt if approval is not required (Red Book changes, etc.). Compare the final approval date or receipt date as appropriate to the date the update was input to the system.

4. Inpatient hospitals and Long-Term-Care Facilities are excluded.

5. Use scoring chart D, page 11-4-23.

Factor 2D2: The approved Medicaid payment for services and items must be accurately posted on the pricing file.

PERFORMANCE LEVEL: 99 percent of pricing file changes must reflect that payments posted on the pricing file are accurate.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Use the normal sample selected for Factor 2D1. For collective updates, select one (1) entry from the medium (tape, disc, etc.).

2. Verify that the amounts posted on the pricing file are accurate. The amount on the pricing file must be compared to the most recent source document indicating a change.

3. Use scoring chart D, page 11-4-23.

Factor 2D3: The State must provide an updating facility for the Procedure, Diagnosis, and Formulary file(s).

PERFORMANCE LEVELS: The State must be capable of updating the Procedure, Diagnosis, and Formulary File(s).

Use defined scoring as follows:

a. Zero (0) points if the system is capable of updating the files, creating audit trails, and producing associated listings requested by those who approve and update the files.

b. Two (2) penalty points if the system does not have the capability to update the files, create audit trails, and produce associated listings to verify that the updates were made or show the contents of the file.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Review the State's written procedures for updating the reference support data base (file) to determine the approval process for changes.

2. Review the audit trail for a current reference file update. If the system is operating correctly and no unauthorized changes were made, assume capability.

Factor 2D4: The State system must be capable of capturing and accumulating charge data and/or generating fee schedules in accordance with the State plan and State policies and employing the proper process for pricing claims.

PERFORMANCE LEVEL: Charge data must be captured and accumulated accurately in accordance with the State plan and State policies and procedures.

WEIGHT: 2

METHOD OF EVALUATION:

1. Examine the State's written procedures for capturing and updating charge data. Examine State plan pricing reguirements.

2. Review the methodology employed to price claims (examine fee schedules, charge data, and pricing procedures).

3. Insure that the methodology employed conforms to the stated policies.

4. Use special scoring, page 11-4-17.

11420.3 STANDARD 3 - ORDERLY/TIMELY CLAIMS PROCESSING.--Claims Must Be Processed In An Orderly and Timely Manner From Initial Receipt Through Issuance of Claims Determinations.

NOTE: For purposes of Standard 3 the date of receipt is operationally defined as a date not later than the date of the first workday following the day of actual mailroom receipt. In addition, for SPR purposes electronic media claims (EMCs) are defined as claims submitted on magnetic tape, floppy disc, cassette, etc., or by transmission from remote terminals and CPUs.

A. ELEMENT E.—CLAIMS MUST BE CONTROLLED FROM RECEIPT THROUGH FINAL DISPOSITION, WITH TIMELY ISSUANCE OF COMPLETE CLAIMS DETERMINATION NOTICES.

Factor 3E1: Claims must be controlled with a unique identifier. A date of receipt must be shown on the claim. EMCs are excluded from this factor.

PERFORMANCE LEVEL: 99 percent of claims must be uniquely identified and must have a receipt date that is no later than the workday following the day of mailroom receipt.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Select a normal sample of claims (as defined in 42 CFR 447.45(b) and (c)(2)) from the mailroom. Make copies of the selected claims and return the originals to the mailroom.

2. Request documentation to verify that each claim has a unique identifier (or separate number, if used) incorporating the proper date of receipt. Claims must be uniquely identified and have a receipt date that is no later than the workday following the day of mailroom receipt.

3. The State will have 30 working days from the date of the request to provide the documentation. The regional office representative should inform the State how the original claim or equivalent claim data should be transmitted if the documentation is not obtained onsite.

4. For claims which cannot be located, the State must provide documentation that the claim was returned to the provider. When a State system allows for returns prior to control, an unlocated claim meeting these written "early return" guidelines (as indicated by the sample copy) does not require documentation. If the return is not made according to guidelines, count one error. In all other States, if a claim cannot be located within 30 working days after the request, and there is no documentation to support that it was returned to the provider, count one (1) error per claim. If a claim was not uniquely identified and/or dated properly count one (1) error per claim.

5. Use scoring chart D, page 11-4-23.

Factor 3E2: EMCs must be controlled, entered into the System, and/or rejected in a timely manner.

PERFORMANCE LEVEL: 97.5 percent of EMC submittals must be entered into the system in the next appropriate cycle or within six (6) working days or rejected timely and in accordance with State policy.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Review State procedures for control and processing of EMCs.

2. Select a normal sample of submittal log entries. Review the selected entries to see that EMC submittals are recorded giving pertinent information such as sender I.D., date of receipt, date processed or rejected, etc. Include Medicare crossover claims if submitted via electronic media.

3. Take the above sample and compare computer run dates to determine if the submittal was entered in the next appropriate cycle (generally, the scheduled input of EMCs) or within six (6) working days, whichever is later. If there is an unexplained delay, count as an error. If the submission was rejected the submitter must have been notified within three (3) working days. The actual tape need not necessarily be returned within three (3) working days.

4. Review the sample for rejected submissions to determine if the rejections were in accordance with State policy. If not, count as an error.

5. Use scoring chart D, page 11-4-23.

Factor 3E3: Timely and complete Explanation of Benefits (EOBs) must be produced as required by Federal regulations.

PERFORMANCE LEVEL: 99 percent of EOBs must be complete and produced within 45 days of the payment of claims.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. Select a normal sample of EOBs. Where a State furnishes EOBs for 100 percent of claims services, the sample may be selected as a subset of the adjudicated claims sample from Element G.

2. Compare these EOBs to the date of payment located on the recipient history or other appropriate file.

3. EOBs must be complete as required by regulation and must be produced within 45 days of payment.

4. Regulatory Citation: 42 CFR 433.113 (e) and (f).

5. Use scoring chart D, page 11-4-23.

Factor 3E4: The system must be capable of identifying and controlling all claims transactions that have been entered into the system but not finally adjudicated. The State must demonstrate that it makes use of this information to ensure the adequacy of workflow and control workflow problems.

PERFORMANCE LEVELS: The system must be capable of identifying all transactions that have been entered into the system but not finally adjudicated within the timeframes specified in State policy or in the event no State policy exists, 45 days.

The State must have procedures in place to utilize this information in order to expeditiously adjudicate the transaction so identified.

Use defined scoring as follows:

a. Four (4) penalty points if the system is not capable of identifying those transactions which exceed defined timeframes.

b. Two (2) penalty points if the system has the capability to identify those transactions which exceed defined timeframes, but the State has no procedures, or inadequate procedures, to ensure expeditious adjudication.

c. Zero (0) points if the sytem has the capability and the State can demonstrate that they utilize them.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Verify that the capability exists to identify all claims that exceed threshold timeframes.

2. Verify that procedures exist to take action based on the demonstrated capability.

3. Verify that the State has been following its own procedures by:

a. permitting the State to demonstrate the adequacy of its process, or

b. permitting the State to demonstrate that there are no claims that exceed established timeframes without good cause, or

c. permitting the State to demonstate in any other manner that claims are not permitted to languish within the system without good cause.

B. ELEMENT F.—CLAIMS MUST BE PROCESSED ON A TIMELY BASIS.

Factor 3F1: Ninety percent of clean practitioner claims must be paid or denied as appropriate within 30 days of receipt.

PERFORMANCE LEVEL: The State must pay 90 percent of all clean claims from practitioners who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Use the adjudicated claims sample from Element G.

2. Measure the time elapsed beginning with the date of receipt and through the date of the check or denial notice, or mailing date, whichever is later. For EMC claims, review the EMC control numbering procedures to make sure the correct claims control number is added to the EMC claim or check the submittal log to verify date of receipt.

3. Provider billings which qualify as practitioner claims are listed in Appendix C.

4. Regulatory citation: 42 CFR 447.45(d)(2).

5. See §11415.1 for instructions on how to compute correct percentages for stratified samples. Use scoring chart A, B, C, or D as appropriate.

Factor 3F2: Ninety-nine percent of clean practitioner claims must be paid or denied as appropriate within 90 days of receipt.

PERFORMANCE LEVEL: The State must pay 99 percent of all clean claims from practitioners who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Use the adjudicated claims sample from Element G.

2. Measure the time elapsed beginning with the date of receipt and through the date of the check or denial notice, or mailing date, whichever is later. For EMC claims, review the EMC control numbering procedures to make sure the correct claims control number is added to the EMC claim or check the submittal log to verify date of receipt.

3. Provider billings which qualify as practitioner claims are listed in Appendix C.

4. Regulatory citation: 42 CFR 447.45(d)(3).

5. See §11415.1 for instructions on how to compute correct percentages for stratified samples. Use scoring chart A, B, C, or D as appropriate.

Factor 3F3: Claims other than clean practitioner claims must be paid or denied as appropriate within 30 days as provided in the State Medicaid Manual.

PERFORMANCE LEVEL: 99 percent of claims other than clean practitioner claims must be adjudicated within 30 days of receipt.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Use the adjudicated claims sample from Element G and review all claims not reviewed under 3F1 and 3F2.

2. Measure the time elapsed beginning with the later of the date of receipt or last error correction and through the date of the check or denial notice, or mailing date, whichever is later. The various options for calculating processing time are detailed in Part 11 of SMM, Chapter 3, §11325(c)(1). For EMC claims, review the EMC control numbering procedures to make sure the correct claims control number is added to the EMC claim or check the submittal log to verify date of receipt.

3. See §11415.1 for instructions on how to compute correct percentages for stratified samples. Use scoring chart A, B, C, or D as appropriate.

Factor 3F4: All claims must be paid or denied within 12 months of receipt.

PERFORMANCE LEVEL: 99 percent of all claims must be adjudicated within 12 months of receipt.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Use the adjudicated claims sample from Element G.

2. Measure the time elapsed beginning with date of receipt and through the date of check or denial notice, or mailing date, whichever is later. For EMC claims, review the EMC control numbering procedures to make sure the correct claims control number is added to the EMC claim or check the submittal log to verify date of receipt.

3. Regulatory citation: 42 CFR 447.45(d)(4).

4. Use scoring chart A, page 11-4-20.

11420.4 STANDARD 4 - ACCURATE CLAIMS PROCESSING AND REVIEW.—Claims Data Must Be Accurately Processed and Reviewed.

A. ELEMENT G.—CLAIMS DATA MUST BE PROCESSED ACCURATELY.

The claims processing measurement used in 4G1 for SPR scoring is the percentage of claims processed correctly. In addition to claim error data the region will capture, for all States, the dollar impact of the claims processed erroneously. Use this data in evaluating 4G2. These dollar findings determine a payment error rate which will dictate the CPAS required in the subsequent year. In non-mandatory CPAS States this estimate is a weighted ratio of error payments to total payments in the adjudicated claims sample required for Factor 4G1. In mandatory CPAS States, the estimate is a separate stratified subsample regression estimate based on both State and regional reviews.

In both cases, the payment error rates are computed in central office. The statistical lower limit of these error rates is then derived. This lower limit is used on a State-specific basis to determine if the State meets the 1 percent and $1 million misspent tolerance. Failure of this tolerance requires implementation of a mandatory CPAS for the following year.

For element G a stratified sample of 180 claims is to be selected over a 6-month period. The frequency of sample selection is at the discretion of the regional office. If the sample is selected on a monthly basis, a systematic sample is to be selected with separate intervals for each stratum. If the sample is selected at the end of the period, a simple random sample is to be selected from each stratum. The strata and number of claims required are as follows:

Strata	Number of Claims to Review
1. Drug claims	30
2. Institutional claims	90
3. Non-institutional and All Others	60
Total	180

All claims in the universe must be included in one of the strata. Any questionable or unknown types should be included in the third stratum.

If a systematic sample is used, a separate interval is computed for each stratum based on estimated universe count and required sample size for each stratum. The same intervals are used throughout the evaluation period to select monthly samples from each month's adjudicated claim universe. The intervals are NOT recomputed on a monthly basis. Monthly samples will allow reviews to be completed timely; but actual monthly reviews are not required unless there is an indication that the State may receive penalty points in factor 4G1 or element F. The sample(s) must be drawn in time for the review to be completed and factual issues resolved by June 15 each year. If the estimates of the universe are inaccurate and result in sampling of fewer than 175 total reviewable claims, fewer than 15 claims in any stratum or in oversampling, contact central office for procedures to supplement or reduce the sample. (States using SPR for internal evaluation should contact RO for assistance with such problems.)

Factor 4G1: Claims must be processed accurately and in accordance with regulation.

PERFORMANCE LEVEL: 97.5 percent of all claims must be processed accurately (adjudicated to payment or denial including adjustments by the State agency or its fiscal intermediary).

WEIGHT: 3

METHOD OF RO EVALUATION:

1a. Systematic Sampling.—For each State obtain by automated means the monthly portion of adjudicated claims for each stratum as defined above. In instances where the initial six-month sample results in a marginal failure, it is possible that poor early year performance may be offset by improved late performance. In this instance the regional office may expand the fixed sample for up to two (2) months beyond the base review period of October-March. In expanding this sample it is critical that the sampling intervals be held constant throughout the period. This will result in a final sample size of 240 adjudicated claims.

b. Simple Random Sampling.—At the end of the period, for each State, obtain by automated means a simple random sample of the required size for each stratum. In instances where the initial 6-month sample results in marginal failure, it is possible that poor early year performance may be offset by improved later performance. In this instance the regional office may expand the sample for up to two (2) months beyond the base review period of October-March. In expanding the sample, the number of claims to be reviewed per month should be one-sixth (1/6) of the number of reviews required for the base period per stratum. In addition, monthly universe counts will be required to aggregate the base period and the expansion period.

Where a failure of Standard 4 cannot possibly be overcome by the added two (2) months' sample, no additional months will be reviewed. This point occurs with a 6-month performance level of 86 percent in both mandatory and non-mandatory States.

2. Review.—Review the claims according to the guidelines in Appendix B and record the findings on the "SPR Claims Processing Review Schedule" in Appendix B. Count the number of claims in the sample with one (1) or more errors. Compute the percentage of claims without error. See §11415.1 for instructions on how to compute correct percentages for stratified samples.

3. Using scoring chart A-2, page 11-4-20.

Factor 4G2: Claims must be paid accurately and in accordance with regulation and administrative procedure.

PERFORMANCE LEVEL: None.

WEIGHT: None.

METHOD OF RO EVALUATION:

a. Non-Mandatory CPAS States

1. Record the misspent dollars associated with claims reviewed for Factor 4G1 on the "SPR Claims Processing Review Schedule" in Appendix B.

2. Copies of the Claims Processing Review Schedule should be transmitted to central office so they can be received by June 15, 1987. The resulting lower limit of the payment error rate estimate will be disseminated to the regional offices to allow them to be added to the scoring sheets.

b. Mandatory CPAS States

1. Sampling and Reporting.—In mandatory CPAS States, select a 180 claim systematic subsample from the ongoing stratified State sample. The same stratum subsampling intervals are used throughout the evaluation period. This subsample will result in the selection of approximately 30 claims per month for the payment months of October through March of the assessment year.

2. Subsample Selection.—State review findings are submitted to the region on a flow basis as reviews are completed. The subsample of 180 adjudicated claims is selected only from the submitted completed reviews. Any claims reviews not completed by the State due to their inappropriate selection in the sample will be validated and approved for exclusion by the region. An example of erroneously sampled claims is payments for 100 percent State funded programs.

As State review findings are received in the regional office, a systematic random subsample will be selected on a flow basis. This subsample will be selected independently for each stratum. This is accomplished by considering each stratum's subsample to be an independent systematic sample of all State reviews in the corresponding stratum. A single sampling interval is used throughout the evaluation period. The sample will be selected continuously from all State completed reviews submitted through the month. However, a new subsample random start number will be selected for the first completion list of each new month. The subsample of 180 claims is allocated to the strata in proportion to the estimated State sample size for each stratum.

3. Review.—

a. Review the claims using the guidelines in Appendix B and record the data on the "SPR Claims Processing Review Schedule" in Appendix B.

b. Data from the Claims Processing Review Schedule should be transmitted to central office by June 15, 1987. The resulting lower limit of the payment error rate estimate will be disseminated to regional offices to allow them to be added to the scoring sheets.

THIS FACTOR IS USED TO DETERMINE WHICH CPAS A STATE MUST OPERATE IN THE SUBSEQUENT YEAR. OMIT FACTOR SCORE FROM COLUMNS "k" - "o" ON THE STANDARD SCORING WORKSHEET.

B. ELEMENT H.—SYSTEM OPERATIONS MUST APPROPRIATELY INCORPORATE EDITS AND SCREENS.

Factor 4H1: Suspected duplicate claim submissions must be appropriately resolved.

PERFORMANCE LEVEL: 99 percent of suspected duplicate claims must be resolved correctly.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Use normal sampling to draw a sample of duplicate suspects (exceptions). Copy and return to the exception batch. If the State retains hard copy records on duplicate suspects going back to the beginning of the review period, a normal sample may be selected from this source.

2. Ten (10) working days or later request recipient histories for the excepted claims.

3. Compare the histories with the exception reports to verify that the State's duplicate resolution process resulted in appropriate action in each case.

4. Error definition - An inappropriate final action based on either improper application of State resolution procedures or a deficiency in these procedures which resulted in the incorrect action. Payment of outpatient claims which duplicate inpatient services paid utilizing an all inclusive per diem rate is an error condition. Only one (1) error per claim, however, should be counted. If a postpayment resolution process is used, insure that appropriate action has been taken or is in progress.

5. Regulatory citation: 42 CFR 447.45(f)(1)(iii).

6. Use scoring chart D, page 11-4-23.

Factor 4H2: The use of force codes (override codes) must be controlled.

PERFORMANCE LEVEL: 99 percent of claims adjudicated using force codes or edit exceptions resolved via force code must be properly overridden and an audit trail must exist.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. A force code is a code used to indicate which edit condition(s) to ignore during processing.

2. Use normal sampling to draw a sample of claims adjudicated using force codes (resolved pends) or draw a limited scope sample of edit exceptions that were resolved via use of a force code. Exclude automated system overrides which do not require manual processing.

3. Use written State procedures to review claims to determine if the edits were properly overridden; i.e., use was authorized for the situation presented by the claim.

4. Review claims history to insure an audit trail exists that identifies the use of force codes. This audit trail need not be automated. Both items 3 and 4 of this method of evaluation must be met for the claims to pass the review.

5. Use scoring chart D, page 11-4-23.

Factor 4H3: Prepayment consistency and utilization edits/screens must be applied to all processed claims.

PERFORMANCE LEVEL: Systems must have minimum edits in place as required in regulations.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. Obtain the listing of State consistency/utilization edits. As a minimum there must be edits and audits that cross-check between type of service, place of service, procedure code, diagnosis code, age, sex, frequency of service, provider type, or any appropriate combination. Systems which do not have the minimum edits in place as required in regulations will be assessed three (3) penalty points.

2. Regulatory citation: 42CFR 447.45(f)(1)(ii).

3. If the State pays inpatient claims utilizing an all inclusive per diem rate, the edit(s) should check for duplicate outpatient claims. If this edit is not in place count as a minor problem.

4. Use special scoring, page 11-4-17.

Factor 4H4: Claims with potential Third Party Liability involvement must be edited out for review, processed, cost avoided, and/or controlled for recovery in accordance with State and Federal requirements.

PERFORMANCE LEVEL: 97.5 percent of claims with potential TPL involvement must be edited out for review, processed, cost avoided, and/or controlled for recovery in accordance with State and Federal requirements.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Select an intermediate low limited scope sample of claims from 1 month's adjudicated claims with a trauma diagnosis code and/or an indication of worker's compensation coverage, health insurance indicators in the eligibility file, personal injury protection insurance, indication of liability insurance responsible for bodily injury damages or other positive TPL indicator on the claim.

2. At least ninety (90) days after the claims are adjudicated request documentation, including claims history and a profile of recipients involved, to review this factor.

3. Count as an error any of the following conditions:

- Other paid claims for the same recipient were not identified for TPL action, if appropriate or recovery action was not undertaken as provided in State policy and procedures. Do not count more than one error per recipient.

- The threshold for recovery activity was applied incorrectly.

- The processing, including edit resolution, was not in accordance with State and Federal policy.

- Claim controls to insure followup of recovery action and proper crediting of returned funds are inadequate.

4. If for any reason the factor cannot be reviewed as prescribed, review the TPL process in the States including the systems documentation to determine if it is working as intended. Use special scoring on the evaluation.

5. Use scoring chart C, page 11-4-21 for the sampled claims.

6. Record dollar amount of claim in error to document potential misspent funds for informational purposes only to be sent to central office on the final report.

11420.5 STANDARD 5 - MARS.--A Management and Administrative Reporting Subsystem (MARS) Must Be Efficiently and Effectively Operated In Order to Provide Support to Management Review, Evaluation and Decision-Making Processes.

A. ELEMENT I.--REQUIRED FEDERAL REPORTS MUST BE ACCURATE, COMPLETE, AND RECEIVED TIMELY BY THE REGIONAL OFFICE.

Factor 5I1: The HCFA-420 (EPSDT Report) must be received timely by the regional office.

PERFORMANCE LEVEL: The HCFA-420 must be received within 5 working days of the due date.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Compare the date of receipt of each report with the established HCFA due dates.

2. The date of receipt by the HCFA regional office must be recorded or stamped in a uniform way. The date of receipt must be no later than five (5) working days beyond the specified due date. This tolerance factor of five (5) working days represents an absolute. No additional good cause delays will be recognized. A blank report is considered to be a missing report, and penalty points will continue to accrue up to a maximum of three (3).

3. Manual citation: Part 11 of the SMM, chapter 3, §11340(C).

4. Use defined scoring as follows:

a. All reports received before the due date = 1 bonus point

b. All reports received on the due date or within the tolerance = 0

c. One-seventh (1/7) of a penalty point will be accrued for each calendar day beyond the tolerance. To compute penalty points sum the total days late for all reports, divide by seven and round to one decimal point. Do not exceed three (3) penalty points.

d. For States with systems first subject to SPR in the current fiscal year, count one-fiftieth (1/50) of a penalty point for each calendar day late beyond the tolerance for all reports due in the first six (6) months of the State's review period. Subsequent reports should be measured according to MOE 4 (c). To compute penalty points: (1) Sum the total days late for reports due in the first six (6) months, divide by 50 and round to one (1) decimal point; (2) Sum the total days late for subsequent reports, divide by seven (7) and round to one (1) decimal point; and (3) Sum the results and do not exceed three (3) penalty points.

Factor 5I2: The HCFA-2082 (Annual Statistical Report on Medical Care) must be received timely by the regional office or central office, as appropriate.

PERFORMANCE LEVEL: The HCFA-2082 must be received within 5 working days of the due date.

a. Report received prior to the due date = 2 bonus points

b. Report received on the due date or within the tolerance = 0

c. One-fifth (1/5) of a penalty point is accrued for each calendar day beyond the tolerance. To compute penalty points sum the total days late, divide by five (5) and round to one (1) decimal point. Do not exceed three (3) penalty points.

d. For State systems first subject to SPR in the current fiscal year, count one-twentieth (1/20) of a penalty point for each calendar day late beyond the tolerance. To compute penalty points sum the total days late, divide by 20 and round to one (1) decimal point. Do not exceed three (3) penalty points.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Items 1 and 2 of the MOE for Factor 5I1 should be used.

2. Manual citation: Part 11 of the SMM, chapter 3, §11340(C).

3. The receipt date for files submitted under the MEDSTAT system is the day files are received in HCFA central office.

4. Date of submission of data files for 4th quarter of prior fiscal year will be used to evaluate timeliness for States participating in MEDSTAT system. This criterion will be put into effect once a State participating in MEDSTAT system has had a full year's data submission fully accepted by HCFA (i.e., HCFA has accepted a fiscal year, 4 quarters of Claims and Eligibility files, HCFA has been able to construct Form HCFA-2082 for the State, and HCFA has waived the requirement for the State to continue submitting a hard copy Form HCFA-2082). Fourth quarter Claims Files (the CLAIM-IP, CLAIM-LT, CLAIM-OT files) and the Eligibility Files are due at HCFA's central office on November 15. HCFA central office will furnish the date of receipt to the regional offices. Compute the days late for the Claims Files and the Eligibility Files, sum the results, and divide by 2 to calculate the total days late.

5. The correct version of the Form HCFA-2082 must be received in order for the report to be counted as received.

Factor 5I3: The annual HCFA-350 (Provider Participation Report) must be received timely by the regional office.

THIS FACTOR RESERVED FOR FUTURE USE.

Factor 5I4: The State reporting system must be operating to produce statistical reports in accordance with HCFA instructions. States subject to the data validation review (DVR) must correct statistical reporting deficiencies brought to their attention.

PERFORMANCE LEVEL: All corrective actions must be completed timely in accordance with instructions.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. For all deficiencies requiring corrective action by the end of the FY 1987 review cycle (whether those deficiencies were identified in the current or a prior fiscal year), the State must provide documentation which indicates that the appropriate corrections were made. The validation score, for deficiencies not corrected by the end of the cycle, will be derived using the DVR scoring methodology for the fiscal year in which the deficiency was originally identified. These deficiencies are categorized as follows:

a. Deficiencies identified during FY 1984 or FY 1985 and scored under the SPR in FY 1986. For this situation only, the validation score will be doubled.

b. Deficiencies identified in FY 1986 for which corrective action was not required until the end of FY 1987.

c. Deficiencies identified in FY 1987.

2. The validation scores from a, b, and c above will then be totaled and the total score then converted to the SPR penalty points in accordance with the conversion table found in Appendix E of the FY 1987 SPR Guide.

3. A data validation review will be performed in FY 1987 using the review guide found in Appendix E of the FY 1987 SPR Guide. The review will validate the HCFA-2082 in those States that submitted a revised hardcopy HCFA-2082 in FY 1987 and were not reviewed in FY 1986. Unlike previous DVRs, deficiencies brought to the State's attention in FY 1987 must be corrected by the end of FY 1987.

B. ELEMENT J.—THE STATE MUST UTILIZE THE CAPABILITIES OF MARS TO EFFECTIVELY MANAGE AND CONTROL THE MEDICAID PROGRAM AND PRODUCE REQUIRED REPORTS WHICH ARE ACCURATE, COMPLETE, AND RECEIVED TIMELY.

Factor 5J1: The State must provide for on-going use of Management and Administrative Reports by State Management personnel.

PERFORMANCE LEVEL: Management and Administrative Reports must be utilized for the effective and efficient management and control of the Medicaid program.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. State Management and Administrative Reports must, at a minimum, contain information/statistical data for the following target areas as indicated in SMM, chapter 3, §11340(A).

a. Fiscal planning and control.

b. Statistical data to be used in formulating Medical assistance policy and regulations.

c. Claims processing and payment activities.

d. Provider performance, participation, and service delivery.

e. Recipient participation and usage.

2. The State must demonstrate that Management and Administrative Reports are used in managing and controlling the Medicaid program. Such use can be demonstrated by written documentation, such as policy/procedure changes which result from analysis of State Management/statistical reports; by interviews with State Management staff which indicates familiarity, and use of the reports in ongoing management activities, etc. It is considered a major problem if any one (1) target area is not supported.

3. Use special scoring, page 11-4-17.

11420.6 STANDARD 6 - S/URS.-The Operation of a Surveillance and Utilization Review Subsystem (S/URS) Must Provide Comprehensive Health Care Delivery and Utilization Data for Program Management, Reveal Potential Defects in the Quality of Care, and Reveal Suspected Instances of Provider or Recipient Fraud or Abuse.

A. Element K.—AN APPROPRIATE ON-GOING REVIEW OF SERVICE DELIVERY AND UTILIZATION PATTERNS MUST BE MAINTAINED.

Factor 6K1: The State must periodically review an established minimum of active recipients.

PERFORMANCE LEVEL: The State must review a minimum number of active recipients.

Use defined scoring as follows:

a. One (1) bonus point = Exceeded minimum case review requirements.

b. Zero (0) = Met minimum case review requirements.

c. Three (3) penalty points = Did not meet minimum case review requirements.

d. Four (4) penalty points = Did not meet minimum case review requirements for two (2) consecutive years.

e. Five (5) penalty points = Did not meet minimum case review requirements for three (3) consecutive years.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. The State must review each quarter at least .0001 (.01%-rounded to whole number) of the total body of active recipients. Active recipients are those who have incurred at least one (1) paid service during the review period, unless the State's definition is based on a greater number of incurred services. Obtain an unduplicated number of active recipients for the previous year. Use this number to determine the minimum number of reviews necessary for each quarter. At least 80 percent of the established minimum of active recipients to be reviewed must be selected from those identified through the ongoing quarterly exception process. Up to 20 percent of the minimum cases may be identified through other sources, but the information retrieval capabilities of the MMIS (e.g., exception profile, recipient history, etc.) must be used in support of these reviews. Apply the 80/20 percent review requirement to the sum total of minimum quarterly reviews, not to each individual quarter.

2. Credit the review for the quarter in which it is actually initiated rather than excepted or assigned.

3. Review State logs, etc., to assure that minimum review levels are met.

Factor 6K2: The State must periodically review an established minimum of active providers.

PERFORMANCE LEVELS: The State must review a minimum number of active providers.

Use defined scoring as follows:

a. One (1) bonus point = Exceeded minimum case review requirements for all categories.

b. Zero (0) = Met minimum case review requirements.

c. Three (3) penalty points = Did not meet minimum case review requirements.

d. Four (4) penalty points = Did not meet minimum case review requirements for two (2) consecutive years.

e. Five (5) penalty points = Did not meet minimum case review requirements for three (3) consecutive years.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. The State must review each quarter at least .005 (.5%) of the total body of active providers other than inpatient hospital services providers of each of the following service-type groupings:

a. Physicians' Services and Clinic Services

b. All others, including outpatient hospital services

Obtain an unduplicated number of active noninstitutional providers for the previous year. Use this number to determine the minimum number of reviews necessary for each quarter. Credit the review for the quarter in which it is actually initiated rather than excepted or assigned.

States that elect to conduct focused reviews do not have to review every class/peer group of every category of service, or even all minor categories of service quarterly. However, when selective analysis and reporting of this kind is done, every report, category of service, and class group must be run at least once within the first three (3) quarters to assure completeness. **NOTE: THIS REQUIREMENT MUST BE TAKEN INTO CONSIDERATION WHEN REVIEWING ALL AFFECTED FACTORS IN STANDARD 6. IN ADDITION, IF A REVIEW IS DONE EARLY ONE YEAR AND THE REVIEW DOES NOT INCLUDE A RUN WITH ALL CLASS GROUPS AND CATEGORIES OF SERVICE FOR REPORTING PURPOSES, THE REVIEW SHOULD BE DONE LATE ENOUGH IN THE SUBSEQUENT YEAR TO ASSURE THAT ALL CLASS GROUPS, ETC., ARE RUN IN STATES THAT DO NOT RUN ALL CATEGORIES EVERY QUARTER.**

2. The State must review annually a number of Inpatient Hospital Services (IHS) providers as follows:

This portion of the factor is deemed met for those States that perform an alternate utilization review for IHS. However, States must document that they monitor Peer Review Organizations (PRO) or utilization review activities of other entities to assure that contractual obligations are being fulfilled.

a. The following States must review at least 25 IHS providers:

(1) California
(2) Texas
(3) New York

b. The following States must review at least 20 IHS providers:

(1) Pennsylvania
(2) Illinois
(3) Florida
(4) Ohio
(5) Michigan

c. The following States must review at least 15 IHS providers:

(1) Minnesota
(2) Georgia
(3) Missouri
(4) Tennessee
(5) North Carolina
(6) Wisconsin
(7) Kansas
(8) Louisiana
(9) Oklahoma
(10) Indiana
(11) Alabama
(12) Iowa
(13) New Jersey
(14) Massachusetts

d. The following States must review at least ten (10) IHS providers:

(1) Virginia
(2) Mississippi
(3) Washington
(4) Kentucky
(5) Nebraska
(6) Arkansas
(7) Colorado
(8) Oregon
(9) South Carolina
(10) Maryland

e. The following States must review at least five (5) IHS providers:

(1) West Virginia
(2) Montana
(3) South Dakota
(4) North Dakota
(5) Connecticut
(6) New Mexico
(7) Maine
(8) Idaho
(9) Utah

f. The following States must review at least three (3) IHS providers:

(1) New Hampshire
(2) Hawaii
(3) Vermont
(4) District of Columbia

g. States not listed which receive approval for an MMIS during FY 1985 or early FY 1986 and are also subject to SPR must review at least three (3) IHS providers.

3. Active providers are those who have provided at least one (1) adjudicated Medicaid service during the review period, unless the State definition is based on a greater number of services.

4. At least 80 percent of the established minimum of active providers to be reviewed must be selected from those identified through the ongoing exception process. Up to 20 percent of the minimum cases may be identified through other sources, but the information retrieval capabilities of the MMIS (e.g., exception profile, provider history, etc.) must be used in support of these reviews. For non-IHS providers, apply the 80/20 requirement to the sum of minimum quarterly reviews, not to each individual quarter.

5. Review State logs, etc., to assure that minimum review levels were met from exception processing.

Factor 6K3: The State must review active recipients in an acceptable manner.

PERFORMANCE LEVEL: Reasonable progress must be made on 99 percent of active recipient cases reviewed.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. Select a normal sample of recipient cases opened during the fiscal year.

2. Verify that reasonable progress has been made on case activity and that the case has been reviewed.

3. A review is defined as sufficient analysis of the exceptions on the summary profile or of issues identified through other sources in order to resolve the exceptions and take appropriate followup action. Active recipients are those who have incurred at least one (1) paid service during the review period, unless the State's definition is based on a higher number of incurred services.

4. Document that individual cases are manually analyzed and/or reviewed based on medical and/or statistical factors, as appropriate. Documentation must contain the following: 1) the reason(s) the recipient was reviewed (complaint and/or exceptions on the profile); 2) a chronological record of all analysis and review events, decisions made, and all actions taken to deal with the utilization problem, including who made the decisions and the reasons for taking the actions; 3) the information used to perform the review; and 4) a record of all contacts with providers or recipients, including interviews made in person or by telephone contact.

5. Use scoring chart D, page 11-4-23.

Factor 6K4: The State must review active providers in an acceptable manner.

PERFORMANCE LEVEL: Reasonable progress must be made on 99 percent of active provider cases reviewed.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. Select a normal sample of provider cases opened during the fiscal year.

2. Verify that reasonable progress has been made on case activity and that the case has been reviewed.

3. A review is defined as sufficient analysis of the exceptions on the summary profile or of issues identified through other sources in order to resolve the exceptions and take appropriate followup action. Active providers are those who have provided at least one (1) adjudicated Medicaid service during the review period, unless the State definition is based on a greater number of services.

4. The State must document that individual cases are manually analyzed and/or reviewed based on medical and/or statistical factors as appropriate. Documentation must contain the following: 1) the reason(s) the provider was reviewed (complaint and/or exceptions on the profile); 2) a chronological record of all actions taken to deal with the utilization problem, including who made the decisions and the reasons for taking the actions; 3) the information used to perform the review; and 4) a record of all contacts with providers or recipients, including interviews made in person or by telephone contact.

5. Use scoring chart D, page 11-4-23.

Factor 6K5: The State must take actions befitting the analysis of individual cases identified through S/URS.

PERFORMANCE LEVEL: 99 percent of S/URS provider cases closed in the fiscal year must have been processed in accordance with State procedures and policy.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Review a normal sample of provider cases identified by S/URS which were closed in the fiscal year. (This may include cases identified in prior years.) A case is defined to be, at a minimum, an integrity review. An integrity review is the initial process of investigating the aberrancies identified on the provider summary profile. (This process is a result of the quarterly preliminary screening and provider selection activity.)

The integrity review investigation entails obtaining additional data; e.g., provider detail, recipient history, or claim history. The review will be closed after the investigation if it is determined that the aberrancies are not due to overutilization and can be explained; or that a pattern of overutilization or potential fraud warrants the initiation of a full scale investigation.

2. The case development process must be analyzed only to ensure that all nonmedical procedures were followed; e.g., a referral to the proper consultants, etc. If the procedures were not followed, count as an error. In addition, if the appropriate action designated by the reviewers and/or review panel was not followed, count as an error.

3. Use scoring chart D, page 11-4-23.

B. ELEMENT L.—THE STATE MUST PRODUCE SERVICE DELIVERY AND UTILIZATION DATA TIMELY AND ACCURATELY IN SUPPORT OF PROGRAM ADMINISTRATION.

Factor 6L1: S/URS Summary Profile Reports must be produced timely.

PERFORMANCE LEVEL: S/URS summary profile reports must be produced no later than 45/90 days after the close of the report period, as appropriate.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Using production logs, verify run dates for all S/URS Summary Profile Reports. Normally all report runs must be included in the universe. However, if Summary Profile Reports for a particular category of service are run more frequently than once per quarter, exclude from the universe any runs subsequent to the first for that service category.

2. For States which base their profile reports on adjudication dates, S/URS profiles must be produced not later than 45 calendar days after the close of the period reported. For States which base their profile reports on date of service, S/URS profiles must be produced not later than 90 calendar days after the close of the report period.

3. Use small universe scoring (chart F), page 11-4-25.

Factor 6L2: Recipient and provider profiles and reports must be produced.

PERFORMANCE LEVEL:

Use defined scoring as follows:

a. Reports produced as required = 0
b. Each provider class group not produced = 1 penalty point
c. Each recipient class group not produced = 1 penalty point
d. No provider class group reports produced = 7 penalty points
e. No recipient class group reports produced = 6 penalty points
f. Accrue no more than seven (7) penalty points for provider reports and no more than six (6) penalty points for recipient reports.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Verify that the State MMIS produces Management Summary and Summary Profile reports for all categories of services and recipient types (which represent the entire recipient and provider population) at least once during each review period. Each category of service or recipient category must be generated at least as frequently as necessary to support 6K1 and 6K2 case review activity. Long Term Care Summary Profile and Management Profiles and IHS Summary Profiles (when PROs conduct IHS reviews) will not be reviewed.

FACTOR 6L3: THIS FACTOR RESERVED FOR FUTURE USE.

Factor 6L4: Recipient Summary Profile Reports must contain required data and have internal consistency.

PERFORMANCE LEVELS:

Use defined scoring as follows:

a. One bonus point if no errors are found.

b. One-twentieth (1/20) of a penalty point for each entry item deficiency (e.g., a missing report item, an obvious computation error, etc.).

c. One fifth (1/5) of a penalty point for each missing or blank page of an individual report. A blank report is not acceptable for reviewing purposes.

d. To calculate total penalty points sum all penalty points and round in accordance with instructions. A maximum of four (4) penalty points may be accrued.

WEIGHT: 1

METHOD OF EVALUATION:

1. Select a normal sample of excepted recipient summary profile reports or their demonstrable conceptual equivalents.

2. Review the selected reports and verify that they are complete, consistent, and contain no obviously invalid data. Do not attempt to verify data contents per se. It should be recognized that the contents of reports will vary from State to State because of variations in State operations. Some care should be taken in reviewing reports to ensure that obvious deficiencies such as missing report items, blank columns, etc., are in fact improper. A blank space is not automatically an error.

3. Most S/URS have a zero suppress feature which would not produce data for an item when the value of the item is zero (0). For instance, for physicians, required items are counts of office visit and counts of surgical procedures. If a particular physician bills for office visits but not surgery, his report would indicate a value in office visits but there would be no line showing zero (0) surgical procedures. Consequently, to determine whether a system has all of the required items the S/URS control file must be checked to ensure that the required items were used for report production.

4. At a minimum, it is expected that the recipient summary profiles must use a total of at least 20 items reporting on receipt of services exclusive of those used for identification purposes. The following items must be included:

Identification Section

Class Group
Name
Identification Number
Location
Specialty

Services Summary Section

Dollars Paid - Medicaid
Number of Medical Visits
Payments for Medical Visits
Number of Surgical Procedures
Number of Outpatient Procedures
Number of Drug Prescriptions (RX)

5. Specific definitions for each item are established by the States. General definitions are available for information purposes in Section VI of the GSD.

Factor 6L5: Provider summary profiles must contain required data and have internal consistency.

PERFORMANCE LEVELS:

Use defined scoring as follows:

a. One bonus point if no errors are found.

b. One-twentieth (1/20) of a penalty point for each entry item deficiency (e.g., a missing report item, an obvious computation error, etc.).

c. One fifth (1/5) of a penalty point for each missing or blank page of an individual report. A blank report is not acceptable for reviewing purposes.

d. To calculate total penalty points sum all penalty points and round in accordance with instructions. A maximum of four (4) penalty points may be accrued.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Select a normal sample of provider summary profile reports or their demonstrable conceptual equivalents.

2. Review the selected reports and verify that they are complete, consistent, and contain no obviously invalid data. Do not attempt to verify data contents per se. It should be recognized that reports completion will vary from State to State because of variations in State operations. Some care should be taken in reviewing reports to ensure that obvious deficiencies such as missing report items, blank columns, etc., are in fact improper. A blank space is not automatically an error. States which contract with a PRO to conduct hospital reviews will not be reviewed for accuracy of hospital summary profiles.

3. Most S/URS have a zero suppress feature which would not produce data for an item when the value of the item is zero (0). For instance, for physicians, required items are counts of office visits and counts of surgical procedures. If a particular physician bills for office visits but not surgery, his report would indicate a value in office visits but there would be no line showing zero (0) surgical procedures. Consequently, to determine whether a system has all of the required items the S/URS control file must be checked to ensure that the required items were used for report production.

4. At a minimum, summary profiles must use a total of 20 report items (in addition to those items used for identification purposes) for the following provider types: physician services, inpatient hospital services, dental services, and prescribed drugs. All other provider types must use a minimum of at least ten (10) items. The following items must be included for the provider types indicated:

PHYSICIAN SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Medical Visits
Location	Average Number of Visits/Recipient
Speciality	Number of Surgical Procedures
	Payments for Surgery
	Number of Diagnostic Radiology Procedures
	Payments for Diagnostic Radiology Procedures
	Number of Diagnostic Laboratory Procedures
	Payments for Diagnostic Laboratory Procedures

INPATIENT HOSPITAL SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Discharges
Location	Average Stay/Discharge
	Percent Discharges 1 Day
	Percent Discharges 2 Days

OUTPATIENT HOSPITAL SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Services Provided
Location	Average Number of Services/Recipient
	Average Payment/Service

DENTAL SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Services Provided
Location	Average Number of Services/Recipient
	Average Payment/Service

PRESCRIBED DRUGS

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Prescriptions Filled
Location	Average Number of Prescriptions/Recipient
	Average Payment/Prescription

ALL OTHERS

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Services Provided
Location	Average Number of Services/Recipient
	Average Payment/Service

5. Specific definitions for each item are established by the States. General definitions are availble for information purposes in Section VI of the GSD.

C. ELEMENT M.--THE CAPABILITIES OF S/URS MUST BE UTILIZED TO AID IN PROGRAM MANAGEMENT AND SYSTEM IMPROVEMENT.

Factor 6M1: S/URS exception criteria must be adjusted to meet program needs so as to facilitate program evaluation and planning.

PERFORMANCE LEVEL: S/URS exception criteria must be routinely updated.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Review State documentation to determine that S/URS exception criteria are routinely updated to reflect S/URS experience and/or S/URS policy.

2. If no changes were made to the S/URS exception criteria, determine that such inactivity was appropriate or inappropriate in view of State S/URS experience including the case review experience and policy.

3. Use special scoring, page 11-4-17.

Factor 6M2: The State must establish and use S/URS related feedback mechanisms for improving system performance.

PERFORMANCE LEVEL: The State must document that it does, in fact, have a feedback process in place.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. The State must establish and use a feedback mechanism from all users of S/URS outputs and derived data to S/URS staff responsible for defining and controlling those parameters relating to recipient class groupings, provider peer groups, report item definition, and exception criteria.

2. The State must establish and use a feedback mechanism from S/URS staff to other MMIS staff so as to capitalize on S/URS experience and data in the definition and refinement of claims processing edits, procedures, and program policy changes.

3. Verify that the State has established the feedback mechanisms required above. The State must also provide documentation that the mechanisms are used to provide information to assess the need for system, program, and procedural changes. Further, the State must provide documentation of actions taken on the basis of such feedback, although it cannot be expected that all information exchanged will result in changes.

4. Use special scoring, page 11-4-17.

11420.7 STANDARD 7 - MMIS ADMINISTRATION.--Overall Effectiveness in Carrying Out MMIS Administrative Responsibilities Must Be Demonstrated.

A. ELEMENT N.--PRUDENT AND EFFECTIVE SYSTEM MANAGEMENT MUST BE PROVIDED.

Factor 7N1: Effective monitoring of fiscal agents and contractors must be demonstrated.

PERFORMANCE LEVEL: The State must maintain an effective, ongoing program for monitoring contractual services.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Government agencies outside the Single State Agency that furnish claims processing or information retrieval support are included under the definition of fiscal agents/contractors. If the Single State Agency does not utilize a fiscal agent or contractor, the factor is deemed met.

2. Verify that the State data processing facility has an approved service agreement (when data processing services are to be provided by a State central data processing facility or by another State or local agency) with the Single State Agency per 45 CFR 95.611(b)(2). Contracts for data entry are excluded from review for this factor.

3. Review the State's control system for monitoring fiscal agent/contractor operations to assure that performance requirements are being met. Some examples of review criteria might include: a) allocation of staff to monitor the fiscal agent; b) inclusion of clearly defined and measurable performance standards in the contract or memorandum of understanding; c) routine submission of progress reports by the fiscal agent; d) scheduling of periodic State/fiscal agent meetings; e) establishment of a fiscal agent alert system identifying critical issues; and f) State follow-up and resolution of issues/problems.

4. Review State actions taken to resolve unacceptable contractor performance via the enforcement of contractual provisions; e.g., withholding of payment for late or unsatisfactory performance, use of liquidated damages or other actions the State deems appropriate, use of a "cure notice," termination of the contract for cause, activation of performance bond clauses, or use of letter of credit provision.

5. Review State mechanisms for controlling and processing MMIS change orders including: a) criteria used to determine if a change must be effected through a change order; b) system of determining change order priorities; i.e., by type cost, urgency, or level of effort; c) contractor requirements for justification of costs associated with change order; e.g., breakdown of costs by staff, computer time, etc.; d) routine issuance of change order reports by the State; and e) periodic meetings on change orders between State and contractor personnel. Change orders are a recognized means in MMIS contracting for permitting a State to order alterations to the fiscal agent or other contractor contract and to provide for payment to the contractor for that work.

6. Use special scoring, page 11-4-17.

Factor 7N2: The State must have available a current/updated set of program and system documentation.

PERFORMANCE LEVEL: State system documentation must be current and complete.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Review the State's documentation updating procedures.

2. Documentation should include all necessary data to support the system operation, maintenance, data control, backup, etc. Updates should be timely, complete and logged in.

3. Use special scoring, page 11-4-17.

Factor 7N3: The State must have written provider agreements which hold the providers responsible for all EMC data submitted to a State or fiscal agent.

PERFORMANCE LEVEL: 95 percent of providers approved for EMC submittal must have agreements that demonstrate that the integrity of the claim process is adequately protected.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Select a normal sample of providers approved for EMC submittal.

2. Determine if agreements exist for the sampled providers.

3. The agreements should adequately protect the integrity of the claim process. The agreements may include:

   a. signature requirements
   b. access to source documents
   c. source document retention
   d. audit conventions for submittals and source documents
   e. EMC submittal procedures
   f. EMC record layouts
   g. service verification
   h. provider certification
   i. other provisions as determined by the State

4. Count as an error if the integrity of the claims is not protected.

5. Use scoring chart D, page 11-4-23.

Factor 7N4: The State must exercise effective internal quality control (QC) of claims processing and payment through its approved claims processing assessment system (CPAS).

PERFORMANCE LEVEL: The State must effectively operate the approved CPAS.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Determine that the State is operating a CPAS that conforms with the system approved by HCFA.

2. Determine if minimum error conditions are addressed and reflected for States where a mandated system is required or the State has elected to use the mandated system. Use the guidelines in Part 11 of the State Medicaid Manual, CPAS Review Process to evaluate this factor.

3. Use special scoring, page 11-4-17.

Factor 7N5: The State must take corrective action on problems identified through CPAS.

PERFORMANCE LEVEL: The State must take those actions identified in the corrective action plan.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Review the State's most recently approved CPAS corrective action plan. The plan must address claims processing deficiencies identified through the CPAS program.

2. The State must have made reasonable progress in the implementation of the corrective action plan. Progress should be determined based on the nature of the problems to be corrected and the schedule for corrective action, as outlined in the plan.

3. Use special scoring, page 11-4-17.

Factor 7N6: The State must implement new systems requirements per regulations and Federal Register notice.

PERFORMANCE LEVELS:

Use defined scoring as follows:

a. Zero (0) points for each new system requirement implemented, or delayed with HCFA's approval.

b. Three (3) penalty points for each system requirement not implemented and the delay not approved by HCFA.

c. Four (4) penalty points for each system requirement not implemented for two (2) or more review periods and the delay was not approved by HCFA.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Review systems documentation and outputs provided by the State to demonstrate the utilization of the following in accordance with HCFA instructions:

a. The Uniform Hospital Bill (HCFA Form 1450)
(Required effective 01-01-86)

b. The Common Physician Claim Form (HCFA Form 1500)
(Required effective 10-01-86)

c. The International Classification of Diseases - 9th revision, claimed modification (ICD-9-CM) - Diagnosis Coding Only
(Required effective 01-01-86)

d. The Common Procedure Coding System (HCPCS)
(Required effective 10-01-86)

e. The Standard EMC Format
(Required effective 01-01-86)

2. This factor will be used to evaluate the implementation of new requirements and requirements not implemented from prior years.

Factor 7N7: The State must have written procedures including specific TPL questions and resulting data that cover the full range of TPL activities including the recipient intake process to the State's cost avoidance and benefit recovery activities, trauma diagnosis processing, and data match for the title XIX program.

PERFORMANCE LEVEL: Written procedures regarding TPL must conform to the State plan/policy and must support the administrative process from the recipient intake interview questionnaire to both cost avoidance and benefit recovery activities. TPL outputs must be produced by the system and forwarded to the TPL unit.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. Review the States' policy and procedures for capturing TPL data from the eligibility determination, cost avoidance, and TPL recovery activities. The policy and procedures must cover required data derived from TPL questions asked at the eligibility interview and verification followup, recovery procedures (including regulatory requirements to seek reimbursement within 60 days after the end of the month when payment was made), referrals to State TPL unit, the amount of threshold(s) for pursuit of TPL, and retention of insurance coverage data.

2. Review the State Plan and ascertain if the systems procedures conform to the State Plan.

3. Verify that the regional office has approved the dollar threshold used to determine the cost effectiveness to pursue benefit recovery actions.

4. Verify that third party liability information is produced and forwarded to the State's TPL unit in accordance with State requirements and guidelines.

5. Use special scoring, page 11-4-17.

NOTE: This factor is scored and reported for monitoring purposes only in FY 1987. However, if the Federal regulation is published and provides for State implementation, incorporating TPL into the MMIS by March 31, 1987, the factor score will be included as part of the SPR evaluation.

Factor 7N8: The TPL recovery unit must take actions in accordance with Federal regulations, State plan, State policy and procedures.

PERFORMANCE LEVEL: 95 percent of cases reviewed must demonstrate appropriate actions; i.e., actions which conform to Federal regulations, State plan, State policy and procedures.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Select an intermediate high sample of closed and pending cases from the TPL recovery unit files.

2. Review the cases to determine if action was taken. State policy and procedures determine necessary action, but it must include:

a. Research of potential third party resources and cases to obtain sufficient information to file a claim against the third party,

b. filing the claim for payment with the third party,

c. document the response from the third party,

d. periodic review of pending cases to determine appropriate followup,

e. using data obtained from the third party to update the TPL information available to the MMIS, and

f. in cases involving litigation, ensure that State's subrogation law is used to make the State a party in any judgement or settlement.

3. For closed cases, review to ensure that financial controls have been set to indicate payment received or that the absence of a third party resource is documented.

4. Use scoring chart B, page 11-4-21.

NOTE: This factor is scored and reported for monitoring purposes only in FY 1987. However, if the Federal regulation is published and provides for State implementation, incorporating TPL into the MMIS by March 31, 1987, the factor score will be included as part of the SPR evaluation.

Factor 7N9: The State must show a positive ratio of benefits recovered to the cost of recovery.

PERFORMANCE LEVEL: Positive ratios of cost of TPL recoveries to the cost of the recovery operation must be shown.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Obtain from the State the amount of TPL recoveries during the review period. Include a list of items which the State incorporated in TPL recoveries.

2. Obtain from the State the amount of the cost of recovering TPL. Include a list of items which the State incorporated in the cost of recovering the TPL.

3. Compute the ratio of TPL recoveries to the cost of TPL recoveries.

4. Use special scoring, page 11-4-17.

NOTE: This factor is scored and reported for monitoring purposes only in FY 1987. However, if the Federal regulation is published and provides for State implementation, incorporating TPL into the MMIS by March 31, 1987, the factor score will be included as part of the SPR evaluation.

B. ELEMENT O.—ADEQUATE INTERNAL SYSTEM INTEGRITY AND SAFEGUARDS FOR INFORMATION ON RECIPIENTS SHOULD BE ASSURED.

Factors in Element O are deemed met during FY 1987 if each of the following conditions is met:

1. The specific factor was not assessed any penalty points during the FY 1986 SPR.

2. The regional office is not aware of problems which have arisen in that specific area. If the regional office is aware of problems, the State must be notified in writing as soon as possible.

3. The State certifies in writing to the regional office that there has been no decline in performance in these areas since the FY 1986 SPR was completed.

Factor 7O1: Appropriate administrative, technical, and physical system integrity safeguards should be established and utilized.

PERFORMANCE LEVEL: The State must establish and use safeguards to assure system integrity.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. Verify the existence of safeguards designed to assure the integrity of system hardware, software, records, and files. Examples of such safeguards may include:

Administrative

a. Orienting new employees to security policies and procedures.

b. Conducting periodic review sessions on security procedures, including significant changes.

c. Developing listings of personnel to be contacted in the event of a security breach.

d. Maintaining entry logs for limited access areas.

e. Maintaining an inventory of State controlled MMIS assets. (This does not include any financial assets.)

f. Performing a periodic risk analysis, a systematic method for anticipating mishaps and determining the cost-effectiveness of safeguards.

Physical

a. Limiting physical access to systems hardware.

b. Maintaining confidential and critical materials in limited access, secured areas.

c. Maintaining the physical security and integrity of Medicaid eligibility identification media; e.g., cards, sticky labels, and other identifiers used to identify Medicaid eligibles.

Technical

a. Establishing a hierarchy of system access codes with system monitoring and reporting of attempted unauthorized use of codes.

b. Requiring multiple authorizations for program and file changes.

2. Interview appropriate staff to determine if established safeguards are utilized.

3. Manual citation: Part 11 of State Medicaid Manual, Chapter 3, §11300(B)4.

4. Use special scoring, page 11-4-17.

Factor 702: The State must establish appropriate criteria for safeguarding and disclosing Medicaid information.

PERFORMANCE LEVEL: The State must document that it has a plan that safeguards the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

WEIGHT: 1

METHOD OF RO EVALUATION:

1. Review State criteria and procedures for safeguarding and disclosing recipient and claims information. These criteria/procedures must meet the requirements of Federal regulations. Verify that these procedures are actually used.

2. Regulation citations: Safeguarding of Information - 42 CFR 431.301, 431.305, Release of Information - 42 CFR 431.306.

3. Use special scoring, page 11-4-17.

Factor 703: Written recovery and backup procedures to prevent extended disruption of services in emergency situations must be established.

PERFORMANCE LEVEL: The State must demonstrate that all approved recovery and contingency plans/procedures are in order.

WEIGHT: 1.5

METHOD OF RO EVALUATION:

1. Verify that the State maintains, and is reasonably capable of implementing, an established written procedure to handle emergency situations. The procedure should contain a contingency plan to deal with emergencies and provide documentation on the method of recovery of operating systems software. A State's capability is assessed in terms of control over people, facilities, equipment, and money.

2. Responsible staff must be knowledgeable in the method of implementation of such procedures.

3. Review the State contingency plan in dealing with systems software, system libraries, and critical data sets along with master files. Verify that these materials are duplicated and stored at an off-site facility.

4. Use special scoring, page 11-4-17.

11420.8 STANDARD X - AUTOMATED ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEMS.—Automated Eligibility Determinations Must Be Made in an Efficient and Effective Manner.

This standard measures the performance of approved Medicaid eligibility determination systems which are receiving enhanced funding from the Health Care Financing Administration. The review is conducted in FY 1987 as a dry run to further develop a systems performance data base. Consequently, the results of the review will not affect the enhanced matching funds for Medicaid Management Information System (MMIS) operations. This performance standard will not affect funding until it is promulgated in the Federal Register.

A. ELEMENT 1: INTAKE PROCEDURES MUST BE ACCURATE AND TIMELY.

Factor X1a: An eligibility determination/calculation must be made in a timely manner.

PERFORMANCE LEVEL: 97.5 percent of eligibility determinations/calculations must be made timely (within 45 days of application).

WEIGHT: 1.5

METHOD OF RO EVALUATION

1. Select an automated intermediate low sample of recipient eligibility applications filed within the current review period and processed to final disposition. Request a photocopy of the complete hard copy recipient case file. The State must submit these photocopies to the regional office within 45 days of the request. At the same time the hard copy file is requested, secure a copy of all available screens in the automated eligibility determination system for the sample cases.

2. Compare the application dates and the resolution dates for each individual case. The application date is the date a completed signed application is filed for benefits. The resolution date is the date the agency mails notice of its decision to the applicant. All eligibility determinations/calculations must be made within 45 days of the application. Measure the time elapsed beginning with the day the application was filed through the date of resolution.

3. The agency must determine eligibility within these stated periods except in unusual circumstances; e.g., when a decision cannot be reached because the applicant, or a provider delays or fails to take a required action, or there is an administrative emergency beyond the State's control. The reason for the delay must be fully documented in the case folder.

4. Regulatory citation: 42 CFR 435.911.

5. Use scoring chart C, page 11-4-21.

Factor X1b: Accurate eligibility data must be recorded on the automated eligibility determination system.

PERFORMANCE LEVEL: 97.5 percent of required eligibility data must be accurately recorded on the State's automated eligibility system.

WEIGHT: 2

METHOD OF RO EVALUATION

1. Use the intermediate low sample of eligibility cases from factor X1a.

2. Compare the information from the hard copy case folder to the system generated eligibility information. The following data elements, as required by the State Medicaid Manual, part 15, chapter 4, must be posted accurately. Data element numbers 1.01-1.05, 1.07, 1.09-1.12, 1.20-1.24, 1.27, 1.29-1.31, 1.36, 1.41-1.45, 1.71-1.73, 2.01, 2.03, 2.31, 2.34, 2.41, 2.44, 3.01, 3.22, 3.60, 4.01-4.03, 4.06-4.13, 5.00, 6.04, 7.03. Only count one error per case.

3. Use scoring chart C, page 11-4-21.

Factor X1c: Accurate eligibility data must be recorded on the MMIS.

PERFORMANCE LEVEL: 97.5 percent of required eligibility data necessary for claims processing must be accurately recorded on the MMIS.

WEIGHT: 2

METHOD OF RO EVALUATION:

1. Use the intermediate low sample of eligibility cases from Factor X1a.

2. Compare the information from the hard copy case folder to the system generated eligibility information. The following data elements, as required by the State Medicaid Manual, part 11, chapter 3, must be posted accurately. Data element numbers 1-9, 12-14, 28, 121. Count only one error per case.

3. Use scoring chart C, page 11-4-21.

Factor X1d: Eligibility data must be verified by the State in accordance with established policies/procedures.

PERFORMANCE LEVEL: 97.5 percent of required eligibility data must be verified in accordance with established policies/procedures.

WEIGHT: 1.5

METHOD OF RO EVALUATION

1. Use the intermediate low sample of eligibility cases from factor X1a.

2. Review State procedures to determine the data which must be verified for eligibility.

3. Check the automated eligibility case records/case folders to determine if the data fields reviewed in factor X1b have been verified as required by the State. Count unverified data as an error unless verification is pending. Count only one error per case.

4. Use scoring chart C, page 11-4-21.

Factor X1e: A unique identifier must be assigned to each Medicaid recipient.

PERFORMANCE LEVEL: 99 percent of Medicaid recipients must be assigned a unique identifier.

WEIGHT: 1.5

METHOD OF RO EVALUATION

1. Use the intermediate low sample of eligibility cases from factor X1a.

2. Check the sample against information available in the State's automated eligibility determination system and in the MMIS for duplicate names, social security numbers, recipient identification numbers, date of birth, sex, and address. To accomplish this obtain the name, date of birth, sex, and address of each recipient in the sample. Conduct data matches using name, social security number, and recipient identification number. Then query the system to determine if any of these data matches up to other recipients in the automated eligibility determination system and the MMIS. Count only one error per case.

3. Use scoring chart C, page 11-4-21.

B. ELEMENT 2.—THE CASE MANAGEMENT SYSTEM MUST SUPPORT PROGRAM OBJECTIVES.

Factor X2a: A redetermination date must be accurately established for each eligibility case.

PERFORMANCE LEVEL: 97.5 percent of all eligibility cases must have a redetermination data accurately posted on the recipient history.

WEIGHT: 1.5

METHOD OF RO EVALUATION

1. Use the intermediate low sample of eligibility cases from factor X1a.

2. Review State procedures to determine when redeterminations must be scheduled for each category of recipient eligibility. Use the recipient history to determine if the redetermination date has been accurately posted. The reviewer should take into consideration an operation which could be considered a demonstrable conceptual equivalent to the posting of a redetermination date; e.g., monthly runs matching last redetermination date to current operating month to determine who on the entire file is subject to a redetermination for the current month.

3. Regulatory Citation: 42 CFR 435.916.

4. Use scoring chart C, page 11-4-21.

Factor X2b: The system must be utilized to support the eligibility determination process.

PERFORMANCE LEVEL: 97.5 percent of all eligibility cases must be processed through the system to calculate the type and extent of benefits available to an individual.

WEIGHT: 2

METHOD OF RO EVALUATION

1. Use the intermediate low sample of eligibility cases from factor X1a.

2. Review State procedures to determine proper eligibility criteria. Determine if case was processed through the system to calculate type and extent of benefits. Information in the case folder to verify performance may include but is not limited to some of the following: automated data input documents indicating raw data necessary to make eligibility calculation; printouts in file indicating automated calculation; or handwritten manual calculations which indicate the lack of automated calculation.

3. Use scoring chart C, page 11-4-21.

Factor X2c: The State must utilize the information retrieval capabilities of the automated eligibility determination system in the operation of the Medicaid program.

PERFORMANCE LEVEL: The system must generate management reports as required; and the State must demonstrate that those reports are used to achieve program goals.

WEIGHT: 1

METHOD OF RO EVALUATION

1. Verify that the system generates management reports on a periodic or on demand basis. Obtain a list of management reports available from the subsystem as well as a listing of those that were actually produced during the period sampled. These reports include but are not limited to pending case reports, aged case reports, redetermination due reports, purged case reports, social security number enumeration reports, and error reports.

2. The State must demonstrate through documentation and interviews that eligibility management reports are used. The reports must be produced as required by State procedure and used to accomplish program goals.

3. Use special scoring, page 11-4-17.

MARS WORKSHEET FY 87
SYSTEM FIRST SUBJECT TO SPR

STATE REGION

	FY 87 REPORTS	QTR OCT	QTR JAN	QTR APR	QTR JUL	BONUS POINTS	TOT DAYS LATE 1/	PENALTY POINTS
HCFA 420	REPORT FOR	JUL-SEP	OCT-DEC	JAN-MAR	APR-JUN			
	DUE DATE	10/30/86	1/30/87	4/30/87	7/30/87			
	DATE RECEIVED							
	DAYS LATE 1/					2/	8/	4/
HCFA 2082 HARD COPY	REPORT FOR		FY 86					
	DUE DATE		1/15/87					
	DATE RECEIVED					3/		
	DAYS LATE 1/							5/
HCFA 350	REPORT FOR			FY 86				
	DUE DATE			4/15/87				
	DATE RECEIVED					6/		
	DAYS LATE 1/							7/

1/ INDICATE IN THE TOP HALF OF THE BLOCK THE ABSOLUTE NUMBER OF DAYS THE REPORT IS LATE. INDICATE IN THE BOTTOM HALF THE NUMBER OF DAYS THE REPORT IS LATE MINUS THE FIVE WORKING DAYS TOLERANCE.

2/ ONE BONUS POINT IF ALL 4 REPORTS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 511 ON THE SPR SCORING WORKSHEET.

3/ TWO BONUS POINTS IF THE REPORT IS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 512 ON THE SPR SCORING WORKSHEET.

4/ FOR NEW SYSTEMS SUM OF DAYS LATE FOR REPORTS DUE IN THE FIRST 6 MONTHS DIVIDED BY 50 AND ROUND TO ONE DECIMAL POINT; PLUS THE SUM OF DAYS LATE FOR SUBSEQUENT REPORTS DIVIDED BY SEVEN AND ROUND TO ONE DECIMAL POINT (DO NOT EXCEED 3). THIS FIGURE IS TO BE ENTERED IN COLUMN J FOR FACTOR 511 ON THE SPR SCORING WORKSHEET.

5/ FOR NEW SYSTEMS SUM OF DAYS LATE DIVIDED BY 20 AND TRUNCATE TO ONE DECIMAL POINT (DO NOT EXCEED 3). THIS FIGURE IS TO BE ENTERED IN COLUMN J FOR FACTOR 512 ON THE SPR SCORING WORKSHEET.

6/ ONE BONUS POINT IF THE REPORT IS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 513 ON THE SPR SCORING WORKSHEET.

7/ FOR NEW SYSTEMS SUM OF DAYS LATE DIVIDED BY 28 AND ROUND TO ONE DECIMAL POINT (DO NOT EXCEED 3). TO BE ENTERED IN COLUMN J FOR FACTOR 513 ON THE SPR SCORING WORKSHEET.

8/ INDICATE IN THE TOP HALF OF THE BLOCK THE SUM OF THE COLUMNS WHICH REPRESENTS THE ABSOLUTE NUMBER OF DAYS THE REPORT IS LATE. INDICATE IN THE BOTTOM HALF THE SUM OF THE COLUMNS WHICH REPRESENTS THE NUMBER OF DAYS THE REPORT IS LATE MINUS THE FIVE WORKING DAYS TOLERANCE.

MARS WORKSHEET FY 87
PREVIOUSLY REVIEWED SYSTEM

STATE REGION

	FY 87 REPORTS	QTR OCT	QTR JAN	QTR APR	QTR JUL	BONUS POINTS	TOT DAYS LATE 1/	PENALTY POINTS
HCFA 420	REPORT FOR	JUL-SEP	OCT-DEC	JAN-MAR	APR-JUN			
	DUE DATE	10/30/86	1/30/87	4/30/87	7/30/87			
	DATE RECEIVED							
	DAYS LATE 1/					2/	8/	4/
HCFA 2082 HARD COPY	REPORT FOR		FY 86					
	DUE DATE		1/15/87					
	DATE RECEIVED					3/		
	DAYS LATE 1/							5/
HCFA 350	REPORT FOR			FY 86				
	DUE DATE			4/15/87				
	DATE RECEIVED					6/		
	DAYS LATE 1/							7/

1/ INDICATE IN THE TOP HALF OF THE BLOCK THE ABSOLUTE NUMBER OF DAYS THE REPORT IS LATE. INDICATE IN THE BOTTOM HALF THE NUMBER OF DAYS THE REPORT IS LATE MINUS THE FIVE WORKING DAYS TOLERANCE.

2/ ONE BONUS POINT IF ALL 4 REPORTS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 511 ON THE SPR SCORING WORKSHEET.

3/ TWO BONUS POINTS IF THE REPORT IS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 512 ON THE SPR SCORING WORKSHEET.

4/ THE SUM OF DAYS LATE DIVIDED BY 7 AND TRUNCATE TO ONE DECIMAL POINT (DO NOT EXCEED 3). THIS FIGURE IS TO BE ENTERED IN COLUMN J FOR FACTOR 511 ON THE SPR SCORING WORKSHEET.

5/ SUM OF DAYS LATE DIVIDED BY 5 AND ROUND TO ONE DECIMAL POINT (DO NOT EXCEED 3.) THIS FIGURE IS TO BE ENTERED IN COLUMN J FOR FACTOR 512 ON THE SPR SCORING WORKSHEET.

6/ ONE BONUS POINT IF THE REPORT IS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 513 ON THE SPR SCORING WORKSHEET.

7/ SUM OF DAYS LATE DIVIDED BY 7 AND ROUND TO ONE DECIMAL POINT (DO NOT EXCEED 3). THIS FIGURE IS TO BE ENTERED IN COLUMN J FOR FACTOR 513 ON THE SPR SCORING WORKSHEET.

8/ INDICATE IN THE TOP HALF OF THE BLOCK THE SUM OF THE COLUMNS WHICH REPRESENTS THE ABSOLUTE NUMBER OF DAYS THE REPORT IS LATE. INDICATE IN THE BOTTOM HALF THE SUM OF THE COLUMNS WHICH REPRESENTS THE NUMBER OF DAYS THE REPORT IS LATE MINUS THE FIVE WORKING DAYS TOLERANCE.

APPENDIX B

SPR Claims Processing Review Procedures

APPENDIX B

SYSTEM PERFORMANCE REVIEW CLAIMS PROCESSING REVIEW PROCEDURES (ELEMENT 4G)

PURPOSE

The purpose of the claims processing (CP) review is to provide an ongoing mechanism for evaluating CP systems and to provide HCFA with national data on CP operations. CP findings are based on the review of a statistical sample of adjudicated claims. Analysis of CP data provides HCFA with a mechanism for evaluating Federal claims processing policies and procedures and for identifying deficient State CP practices.

OVERVIEW

The CP sample universe consists of all claims adjudicated to payment or denial including adjustments by the State agency or its fiscal intermediary. Claims are subject to sample selection in the month in which adjudication is final rather than in the month in which the services were provided or in the month in which payments were actually made to the provider. Adjustments which either increase or decrease previous payment authorizations are also subject to sample selection and review.

The CP review provides data on the incidence of CP errors and the resulting cost. Once a claim is selected for review, it is reviewed to determine (1) if it was processed in accordance with the State's CP procedures and (2) if the payment/adjustment was correct. A CP Review Schedule is completed for each claim selected for review and is used to record information regarding the errors found.

The CP review is conducted in two major phases and produces two types of findings. In the first phase, the claim is reviewed to determine if it was processed correctly. That is, was all necessary documentation present, were all required procedures followed, were coding or data entry errors made, etc. Processing errors may occur in the CP system itself, or in its supporting manual interface. It is important to review not only procedure, but also decisions. It is possible to correctly follow established procedures, but still err at various decision points within those procedures. The CP review looks at the information available at the time the claim was processed to determine if correct CP decisions were made. If processing errors were made, an occurrence error is recorded on the CP Review Schedule. Occurrence errors may or may not result in an incorrect payment/adjustment. (The State may make errors in processing the claim but the payment authorization may still be correct.)

In the second phase the reviewer develops any occurrence errors found to determine whether they caused the payment to be incorrect. Development means that CP reviewers obtain missing documentation, rework payment computations, or perform other activities necessary to determine if the payment was correct. If incorrect, a dollar error is cited on the CP Review Schedule. Dollar errors are described in terms of the type and amount of the error. A dollar

error finding is recorded on the CP Review Schedule with the occurrence error which was most responsible for the dollar error. As a result, statistical data are generated which describe the relationship between occurrence and dollar errors in State CP systems.

DEFINITIONS

Use the following definitions within the context of the CP review system.

Adjudication - That point in the claims process at which a final decision has been reached to pay or deny a claim.

Amount Approved - The amount adjudicated for payment by the State regardless of the amount of the check subsequently issued to the provider.

Dollar Error - An error that resulted in an erroneous payment; i.e., an overpayment, underpayment, or total dollar error.

Medicare Crossover Payment - Payment by the State Medicaid agency for the Medicare deductible and coinsurance amounts.

Occurrence Error - An error that occurred during processing which may or may not result in a dollar error. For the purposes of the SPR occurrence errors are only assessed where the accurate processing of claims or the accumulation of accurate claim information is affected.

Overpayment - A dollar error in which the amount approved is in excess of the correct amount.

Permissible State Practice - Written State policy instructions which are not inconsistent with the State plan or with approvable State plan amendments which have been submitted to, but not yet acted upon by, HHS.

Prior Authorization - Prior approval by the State agency to reimburse a provider for a specific service, if rendered.

Provider Listing - An official State registry of providers and facilities authorized to receive reimbursement for services provided to State Medicaid recipients.

Recipient History File - A file, covering a period of time, of medical services received by a recipient for which Medicaid reimbursement was requested. The listing should provide the information necessary to conduct the review; i.e., the service rendered, units of service, date of service, provider of the service, date of and amount approved, third party payment data, etc.

Sample Unit - A line item(s) representing the lowest level of claim/adjustment adjudication. The most detailed claim breakdown for which a payment/adjustment determination is made and authorized. For purposes of this guide, a sample unit is referred to as a "claim" in narrative discussions.

Total Dollar Error - An overpayment for the full amount approved.

Underpayment - A dollar error in which the amount approved is less than the correct amount.

SCOPE OF REVIEW

The CP review is concerned with the most detailed claim breakdown for which a payment amount was determined and authorized for payment or adjustment; i.e., the lowest level of payment adjudication by the State. In many instances the claim under review (sample unit) is a single service (office visit, drug, etc.) listed as a separate line item on the provider's invoice for which a separate payment decision is made. (Other line items appearing on the same invoice not in the sample unit are subject to separate sample selection and review.) In other instances the sample unit may be several services listed separately on the provider's invoice but grouped together for payment determination purposes, or an inclusive rate payment made for an individual beneficiary (such as some hospital services, nursing home rates, etc.).

For CP purposes, claims processing is considered complete upon final adjudication when a claim is posted to the adjudicated claims file. The claim is reviewed for correctness based on the amount approved. Adjustments (increases and decreases) made subsequent to the claim adjudication are considered separate CP actions and are subject to independent selection and review as part of the CP sample. Adjustments may be in the form of a supplemental payment, a debit or credit to the provider's account, or a new payment authorization after a credit to the provider's account for the amount of the original claim.

The CP review is not limited to the provider invoice information but includes examination of supporting documentation, recipient history files, payment fee schedules, and other source documents required to reach a definitive review finding. The review is conducted in accordance with permissible State practice and these review instructions.

Permissible State Practice and the State Plan - In all instances where State practice conflicts with the State plan (or approvable amendments) State practice is not permissible and the review is conducted in accordance with the provisions of the State plan. Although the State plan preprint is a simplified document, it is designed to be consistent with Federal regulations. Where the State plan does not specifically address an issue and State practice conflicts with Federal regulations, the review is conducted against the CFR and other HCFA guidelines. If, however, the approved State plan specifically addresses an issue but is in conflict with Federal regulations, the review is based on the approved State plan.

State plan amendments submitted for approval but not yet acted upon are considered in effect for review purposes if the amendments are approvable. Plan amendments are approvable so long as they do not conflict with the CFR. Plan amendments which conflict with Federal regulations are not approvable and cannot be honored for CP review purposes. The effective date of an approvable amendment may be prospective or retroactive, but may not be retroactive beyond the beginning of the calendar quarter in which the amendment was submitted. If the effective date of the amendment is not specified, the date it is submitted is the effective date for review purposes. Once submitted, an approvable plan amendment remains in effect unless, and until, it is formally disapproved by the Department.

Parameters of the Review - Although payments, denials, and adjustments are subject to selection in the month of adjudication, the review is conducted in accordance with policies, procedures, fee schedules, etc. in effect on the date(s) the service was provided or the date of adjudication, as specified by permissible State practice. In instances where the service was provided over a period of days, particularly from one month to the next, it may be necessary to apply separate policies or fee schedules to the review when the dates of service span the effective date of a policy or fee schedule change. For example, one fee schedule may have been in effect for some of the services performed, but a different fee schedule became effective for the remaining services provided.

CLAIMS NOT TO BE REVIEWED

Certain types of claims are not to be included in the CP sample. These will normally be eliminated in the sample selection process. Claims not to be included in the sample and considered listed in error if selected are:

- claims which are not processed through the MMIS;
- claims in which the adjudication date is not within the sample month;
- claims for which no Federal matching is claimed; i.e., are paid with State funds only;
- claims that are an end-of-year institutional cost settlement.

CP REVIEW PROCEDURES

The following sections outline the CP review steps, development, and error determination instructions. Claims are reviewed against two criteria: did the system and manual interface follow approved CP procedures (procedure criterion); and, was the claim processed correctly based on available data (decision criterion).

1. Required Documentation

   a. Claim sample selection list.

   b. Claim copy with:
      - prior authorization
      - physician certification form
      - sterilization consent form
      - Medicare EOMB

c. Provider eligibility file record.

d. Recipient eligibility file record for applicable date of service (or other State accepted proof of eligibility).

e. Claim history file: must show at least all claims for the month prior to the month the service was rendered through the date of claim adjudication. Where the State imposes frequency limitations additional claims history may be necessary to review specific claims.

f. Pricing file record.

g. For adjustments, copy of adjustment claim with required attachments.

h. Claim suspense activity record. Displays the flow of the claim through various system processing locations, edit and audit codes against which the claim excepted, and any manual force codes applied during the process. (These data may be available through a single record or multiple sources.) If manual force codes were applied, the State must provide a copy of its applicable force code procedure.

i. Remittance advice.

j. State coding manuals, decision logic tables, fail record layouts, procedure manuals, etc.

k. Evidence that a valid provider agreement exists where required, and the provider was properly licensed/certified when the services were rendered.

2. Claim Identification - Check the invoice or claims file to determine:

a. if the claim was properly selected for review; i.e., was not listed in error;

b. the line item(s) under review;

c. the review parameters established by the date(s) of service and/or adjudication date;

d. the length of time in elapsed days from date of receipt through date of payment (check date, not approval date) or date of denial notice, or mailing date, whichever is later. For EMC claims, review the EMC control numbering procedures to make sure the correct claims control number is added to the EMC claim or check the submittal log to verify date of receipt,

e. the amount approved; and

f. the proper assignment of unique identifiers.

3. Coding/Data Entry Accuracy - Information supplied on the claim should be coded and entered into the system accurately. Any coding or data entry errors uncorrected at the time of final adjudication are cited as occurrence errors. Where information was missing on the original claim, and was inappropriately supplied during the claims process; i.e., without documentation or contrary to permissible State practice a coding/data entry error must be cited.

4. Provider Eligibility - Determine if the provider was certified to participate in the program for the day(s) the service(s) was rendered and was certified to provide the actual service(s) rendered; e.g., laboratories providing tests outside their approved specialties. If an amount was approved for a provider who was ineligible for the dates of service or for that particular service both an occurrence and dollar error must be cited. If no amount was approved, but the claim successfully passed the provider edits, even though the provider was ineligible, an occurrence error must be cited. .

If a provider was eligible and the claim was denied based on provider ineligibility cite an occurrence error. The claim review must be completed before a determination as to dollar error can be made.

5. Recipient Eligibility - Establish that the recipient appeared on the Medicaid eligibility file for the month(s) covered by the date(s) of service or that there was other State-acceptable proof of eligibility.

6. Covered Services - Compare the type of service provided with the services covered under permissible State practice to determine if the claim was for a covered service. This includes reviewing for timeliness of claims submission. If a claim was paid without required service coverage, prior authorization or provider certification, or frequency limitations were exceeded, count an occurrence error. If the claim was denied for lack of this documentation, and it in fact existed, count an occurrence error. More detailed information on specific coverage issues is provided below.

A. Prior Authorization - Providers must obtain approval from the State prior to delivery of certain services if reimbursement is to be provided. Establish if prior authorization was required, if prior authorization was obtained and documented, and that the service provided was not in excess of any limitation set by prior authorization requirements.

Where the State provides for a waiver of prior authorization under certain circumstances, such as an emergency, verify that the waiver and subsequent authorization were granted in accordance with permissible State practice and prior to final adjudication. If waiver and subsequent authorization could have been granted but were not, an occurrence error is cited, but not a dollar error.

B. Level of Care Certification - Where the State plan, or if silent, permissible State practice, requires evidence of certification prior to payment authorization, verify that the required certification was obtained. If not obtained cite an occurrence error. If certification did not exist at the time of final adjudication but an amount was approved for the claim, cite both an occurrence and a dollar error.

C. Duplicate Payment - Ascertain that a separate amount was not previously approved for the service under review; i.e., the payment under review does not duplicate a previous one. (Where a duplicate billing on a single invoice results in a duplicate payment, the claim(s) appearing after the first claim on the invoice is considered a duplicate.) To determine if the sample unit is a duplicate payment, compare the claim against the paid claims history which covers the period of time as defined in the documentation requirements. Payment of an outpatient claim which duplicates an inpatient claim utilizing an all inclusive per diem rate is an error condition. However, do not count as an error if the State uses a post payment resolution process and appropriate action has been taken or is in process.

D. Frequency Limitations - Determine whether a service was provided more frequently than allowed under permissible State practice. To accomplish this consider both the limitation on the number of times a service may be performed and any differences in the rate of payment for initial and subsequent services. Compare the claim against the claims history for the entire period of time the service under review is subject to frequency limitations under permissible State practice.

7. Provider Signature/Certification - Review State criteria regarding what constitutes an acceptable signature; e.g., signature stamp, authorization form for a substitute signature. Determine if required signatures/certifications were provided on the invoice. If not, develop missing information required to complete the review. NOTE: Beginning October 1, 1987, States having a State Plan calling for signature authorization must provide documentation to support the signature of an individual signing on behalf of the supplier of services.

8. Amount Approved - Verify the correctness of the amount approved by consulting fee schedules, reasonable charge profiles, or by recalculating relative value based payments. The correct amount is the lesser of either the amount billed by a provider for a covered service or the amount specified for that service in the appropriate fee schedules, reasonable charge profiles, etc.

9. Complete Notification of Claims Determinations - Remittance advices must permit the provider to identify its claims and must be issued by at least the time of payment.

SPECIAL REVIEW CIRCUMSTANCES

Medicare Crossover Payments - States may provide payment for the deductible and coinsurance for beneficiaries enrolled under Medicare. For beneficiaries enrolled under Part A and Part B but not under a State buy-in agreement, payment for the deductible and coinsurance is for services covered under the State plan. At the State's option, payment under a State buy-in agreement may be made at the Medicare rate or a lower Medicaid rate.

In crossover situations, claims are usually (but not always) processed for payment by Medicare first. Medicare pays the principal part of the provider charge up to the maximum rate, less any deductible and coinsurance amounts.

In processing crossover payments the State agency ascertains the charges allowed and the amount paid (or to be paid) by Medicare. Verify that the Medicare crossover payment was correctly processed and that the claim was processed with an Explanation of Medicare Benefits (EOMB) or its equivalent and other State required documentation.

Third Party Liability - The CP review is concerned with identifying TPL occurrence errors only. Since TPL dollar errors are not within the scope of the CP review, no development of occurrence errors is necessary.

When the State's CP procedures require identification of possible TPL sources, make a determination as to whether the procedural requirements were met. The State's procedures for TPL identification may entail:

- check for TPL involvement when diagnosis codes indicate trauma (800-900 series);
- collecting specific TPL information on the invoice;
- identification of TPL coverage already known to the system;
- TPL edits related to the type of service; or
- tracking claims with known TPL for future recovery.

Adjustments -

A. Amount - Only the net amount of the adjustment is under review. In most instances the adjustment amount is the full amount of the supplemental authorization, credit or debit. In other instances, if the initial payment was cancelled and a new payment authorized to the same provider, the adjustment is the difference between the original amount authorized and the new amount; i.e., the net amount.

Where the original payment is cancelled and a new payment authorized to a different provider, the amount of the adjustment is the amount of the cancellation. The new payment to a different provider is not considered part of the adjustment and is subject to separate sample selection.

B. Correctness - To determine the correctness of adjustments, review them in relation to the correctness of the original adjudication and any prior adjustments. To be correct, the adjustment must be based upon an accurate assumption. For example, an adjustment may be authorized to increase an original payment. This assumes that the original payment was less than can be allowed under permissible State practice. If, however, a review of the original authorization revealed an overpayment, the assumption and adjustment are in error.

Examine both the adjustment and the original adjudication to determine the correct total payment. That is, identify and develop occurrence errors in order to determine the correctness of the original adjudication. Review the adjustment to determine if any original errors found, both occurrence and dollar, were corrected

or otherwise compensated for by the adjustment. If not, the errors carry forward and are coded on the CP Review Schedule for the adjustment. If, for example, a claim was originally processed without required documentation and this documentation was needed to make the adjustment, code an occurrence error to the adjustment if it was not obtained. Of course, an adjustment to cancel the original payment authorization due to a lack of required documentation would be correct. Likewise, any dollar errors occurring in the original payment authorization, if not corrected in the adjustment process, may contribute to an adjustment dollar error. Mass adjustments should be excluded when charging errors which carry forward from prior claims action.

The following outlines the dollar error findings which may result from adjustment reviews.

1. Original Authorization Correct and Paid in the Amount Specified in the Appropriate Fee Schedule -

a. Adjustment to Increase - Net increase reported as total dollar error.

b. Adjustment to Decrease - Net decrease reported as underpayment.

2. Original Authorization Correct but Provider Billed Less Than Specified in Appropriate Fee Schedule -

a. Adjustment to Increase - Correct only if provider requests adjustment.

(1) Net increase correct if in amount of adjustment request or amount specified in the appropriate fee schedule, whichever is the lesser.

(2) Underpayment coded if net increase is less than the correct adjustment as specified in (1) above.

(3) Overpayment coded if net increase is more than the correct adjustment as specified in (1) above.

b. Adjustment to Decrease - Net adjustment reported as underpayment.

3. Original Authorization a Total Dollar Error -

a. Adjustment to Increase - Net amount of increase reported as total dollar error.

b. Adjustment to Decrease -

(1) Any amount of decrease correct up to the amount of original payment authorization.

(2) Any amount of decrease beyond original payment authorization reported as an underpayment.

4. Original Authorization an Overpayment -

a. Adjustment to Increase.—Net amount of increase reported as a total dollar error.

b. Adjustment to Decrease -

(1) Any amount of decrease correct up to the amount of the original overpayment.

(2) Any amount of decrease beyond original overpayment amount reported as underpayment.

5. Original Authorization an Underpayment -

a. Adjustment to Increase -

(1) Any amount of increase correct up to the amount of original underpayment.

(2) Any amount of increase beyond original underpayment reported as overpayment.

b. Adjustment to Decrease -

(1) Net decrease reported as an underpayment.

DEVELOPMENT AND ACTUALIZATION

Development is the process of determining CP Review information needs and obtaining that needed information when the claim and associated documentation furnished by the State are insufficient to support the adjudication decision. It may be that the documentation was never available or it may erroneously not have been forwarded. The specific circumstances control the error determination process.

Actualization refers to the process of determining whether an occurrence error resulted in a dollar error. Thus, it is a special form of development. With the exception of TPL occurrence errors, all occurrence errors are subject to development to the point necessary to determine the effect of the error on the payment adjudication. Although all occurrence errors are cited on the Claims Processing Review Schedule, development to determine dollar errors ceases at the point a total dollar error is found; i.e., the full amount of the claim should have been disallowed. Therefore, develop first those occurrence errors found which could result in a total dollar error.

When necessary to obtain documentation that was required, but missing when the claim was processed, contact the State to obtain the missing documentation. If the State is able to supply documentation and demonstrate that it was available when the claim was processed, no dollar error is cited. If the State must obtain new documentation (i.e., contact the provider, etc.), the correctness of the payment is based upon the new documentation. If the required documentation cannot be obtained or is unacceptable, cite a dollar error. For example, if evidence of prior authorization cannot be obtained, it must be assumed that prior authorization was not granted. Where the system cannot produce paper or film documentation (e.g., only available on-line) the RO must validate the data on-site.

Error Determination - In making an error determination, first record all occurrence errors found using the error code which best describes the error. Determine if the occurrence error(s) resulted in a dollar error(s). If so, record the error type which best describes the dollar error.

Although the CP review is designed to establish a cause and effect relationship between occurrence and dollar errors, the relationship is not always one-to-one. For example, three occurrence errors occur during the processing of the claim, but only one dollar error results. Code all three occurrence errors on the review schedule, but record the resulting dollar error only once. In such instances, determine which occurrence error most directly caused the dollar error.

If the State cannot furnish required documentation timely, occurrence errors are actualized as dollar errors. A suggested schedule for control of the CP review process is found at Appendix D.

ERROR CODES

The error code listing contains a description of CP errors and contains codes necessary for completion of the CP review schedule.

Occurrence Error Codes - All errors are assigned to five codes as follows: (1) Coding/Data Entry, (2) Eligibility, (3) Coverage, (4) Payment, and (5) TPL/Other. These error codes are recorded under the Occurrence heading (Item 10A) of the CP Review Schedule and, with the exception of the TPL related errors, are subject to development to determine if there was also a dollar error. Since further development stops when a total dollar error is found, development should be completed first on those occurrence errors most likely to result in a total dollar error.

1. Coding/Data Entry - Cited when an error is made by the State in coding invoice or payment data, or in entering data unless corrected by the time of final adjudication.

2. Eligibility - Cited when the provider or recipient was not certified as eligible to participate in the Medicaid program during part or all of the service date(s) or the provider was not eligible to provide the service rendered and the claim was paid.

3. Coverage - Cited when permissible State practice prohibits reimbursement for the type or number of service(s) under review. Where coverage is contingent upon the presence of a prior authorization or provider certification and the claim was paid without it, cite a coverage error. If a claim was denied for lack of such documentation, but it was available, also cite a coverage error.

4. Payment - Cited when a computation or payment determination error resulted in an incorrect amount approved (which may be zero) and when errors were made in applying reasonable charge rates, fee schedules, etc., or a duplicate claim was paid.

5. TPL/Other - Cited for non-permissible State practice such as missing signature, known TPL not considered or other error in procedure not specifically listed. TPL-related errors are not subject to development.

Dollar Error Type Codes - There are six error types: (1) No Dollar Error, (2) Total Dollar Error, (3) Overpayment, (4) Underpayment, (5) TPL Procedural Error, and (6) Nondeveloped Procedural Error. A dollar error type must be assigned for each occurrence error.

1. No Dollar Error - Occurrence errors which, when actualized, did not result in a dollar error.

2. Total Dollar Error - Dollar errors in which the full amount of the payment under review should have been disallowed; i.e., an overpayment in the full amount of the payment. Development ends after a total dollar error is identified.

3. Overpayment Error - Dollar errors in which the amount approved was in excess of the correct amount.

4. Underpayment Error - Dollar errors in which the amount approved was less than the correct amount.

5. TPL Occurrence Error - Occurrence errors only. Do not develop these errors to determine if a dollar error resulted. TPL occurrence errors exist when payment is authorized without regard to known TPL infor nation or when required TPL information is missing.

6. Nondeveloped Occurrence Error - Occurrence errors which were: a) not developed to determine if they resulted in a dollar error, or b) resulted in a dollar error but the dollar error is assigned to another occurrence error. Use code 6 to designate occurrence errors which were not developed because actualization ceased after identifying a Total Dollar Error or when several occurrence errors resulted in the same dollar error. (Since the dollar error is coded with the occurrence error most responsible, code other occurrence errors as type 6 - Nondeveloped.)

CLAIMS PROCESSING REVIEW SCHEDULE

Complete a CP Review Schedule (following page B-15) for each sample unit selected for review. Regions should reproduce the schedules locally. Instructions for properly completing each schedule item are given below.

Claim Status - Circle the appropriate abbreviation: CP (clean practitioner), NC (nonclean practitioner), NP (nonpractitioner). This item supports Element 3F. Use Appendix C to classify claims as practitioner or nonpractitioner.

1. Sample Unit Number - Enter the claim control number (invoice - line item number) which identifies within the MMIS the sample unit selected for review.

2. State Code - Enter the two-letter USPS abbreviation for the State in which the review was selected.

3. Sample Month/Year - Enter the month and year that corresponds to the specified sample month from which the sample unit was selected.

4. Stratum/Substratum ID - Enter the stratum/substratum identification code which matches the State determined stratum from which the claim was selected.

5. State Review Number - Enter the six digit review number used by the State (Mandatory CPAS States only).

6. Processing Time - Enter the applicable processing date(s) for the reviewed claims.

   From: Enter the date of receipt in the format YYDDD (Julian Date). To: Enter the date of the check, remittance advice or denial notice in the format YY DDD (Julian Date) for the claim under review, if issued the same day as generated. If not, the region must develop a procedure to determine actual dates. Enter the date of the last error correction in the format YYDDD (Julian Date).

7. Elapsed Processing Days - Enter the total number of days from item 6. Count both the day of receipt and the check/notice day.

8. Amount Approved - Enter the amount approved from the claims history. This is the amount allowed for the claim; however, it may be more than the amount actually paid due to offsets/debits against the providers' receivables; e.g., "zero-pay" claims.

9. Review Results - Circle the letter that corresponds to the review results on the sample unit.

   a. Correct - Circle "a" if no occurrence errors were found during the review.

b. Occurrence Error - Circle "b" if only occurrence errors were found during the review.

c. Dollar Error - Circle "c" if occurrence errors actualized in dollar errors were found during the review.

10. Error Data - Complete this section for each sample unit determined to contain an occurrence error; i.e., letter b or c was circled in item 9.

Occurrence Errors

A. Code - Record the codes for all occurrence errors identified during the review. The acceptable codes - Coding/Data Entry, Eligibility, Coverage, Payment, TPL/Other are described on pages 5 to 7 of this appendix. If more occurrence errors are found on a claim than can be recorded on the CP Review Schedule, use an additional schedule. Complete Items 1, 2, 3, 9, and 10 on the additional schedule and staple it to the original schedule.

Dollar Errors -

Develop each occurrence error recorded to determine if it resulted in a dollar error.

Exceptions: TPL occurrence errors are not developed. Secondly, if the actualization of an occurrence error results in a Total Dollar Error (the full amount of the paid claim being overpaid), the review ends without the development of the remaining occurrence errors. An overpayment or underpayment, however, does not end the review because subsequent errors may offset or compound the first error found.

After actualization of an occurrence error, enter the dollar error data directly across from the occurrence error; i.e., in line with the occurrence error code.

B. Type - Enter the type of the dollar error. The acceptable types - (1) No Dollar Error, (2) Total Dollar Error, (3) Overpayment, (4) Underpayment, (5) TPL Procedural Error, (6) Nondeveloped Procedural Error - are described on pages 11 and 12 of this appendix.

C. Amount - If a 2, 3, or 4 is entered under item 10B, Type, enter the amount, in dollars and cents, of the error. If the number 1, 5, or 6 is entered, the amount field is left blank.

11. Summary - Complete this section if any dollar error amount was recorded in item 10C. If multiple CP Review Scedules are used for a sample unit, complete Item 11 on the original schedule only.

A. Net Dollar Error - Enter the net dollar amount of all dollar errors combined. The net error amount is determined by adding all overpayments together and subtracting all underpayments and is the difference between the amount approved and the correct approval amount.

B. Type - Circle the number which corresponds to the type of the net error finding.

1. No Net Dollar Error - Circle the number "1" if no net dollar error amount.

2. Total Dollar Error - Circle the number "2" if the net amount of all dollar errors results in an overpayment in the full amount of the payment authorization (item 8).

3. Overpayment - Circle the number "3" if the net amount of all dollar errors results in an overpayment but not in a total dollar error.

4. Underpayment - Circle the number "4" if the net amount of all dollar errors results in an underpayment.

SPR CRITICAL MEDICAID ISSUES PROGRAM (CMIP)

ATTACHMENT A

CLAIMS PROCESSING REVIEW SCHEDULE

CLAIM STATUS: ///
CP NC NP

1. Sample Unit Number: ////////////////
2. State: ///
3. Sample Month/Year: //////
4. Stratum/Substratum: ///
5. State Review Number: ///////
6. Processing Time: From: ////// To: //////
7. Elapsed Days: //////
8. Amount Approved: /////////

Last Correction Date: //////

10. Error Data:

Code	Type	Amount	Code	Type	Amount	Code	Type	Amount
//	//	/////////	//	//	/////////	//	//	/////////
//	//	/////////	//	//	/////////	//	//	/////////
//	//	/////////	//	//	/////////	//	//	/////////
//	//	/////////	//	//	/////////	//	//	/////////
//	//	/////////	//	//	/////////	//	//	/////////

11. Summary:

A. Net Dollar Error: /////////

B. Net Error Type (1/2/3/4): //

1. No Net Dollar Error
2. Total Dollar Error
3. Overpayment
4. Underpayment

C. Error Type Review Results (A/B/C): //

A. Correct
B. Occurrence Error
C. Dollar Error

APPENDIX C

Practitioner And Non-Practitioner Claim Types

APPENDIX C

Practitioner and Non-Practitioner Claim Types

This listing is used for determining appropriate claim status under Element 3F and making appropriate entries on the CP Review Schedules.

Practitioner Claims

1. Physician's Services (medicine and osteopathy)
2. Dental Services
3. Clinic Services
4. Family Planning Services (rendered by a physician, clinic, or other practitioner)
5. Laboratory and X-ray Services
6. Prescribed Drugs
7. Early and Periodic Screening
8. Rural Health Clinic Services
9. Sterilization Services (rendered by a physician, clinic or other practitioner)
10. Other Practitioner's Services (chiropractors, podiatrists, psychologists, registered or licensed practical nurses providing private duty nursing services, optometrists, physical therapists, occupational therapists, speech pathologists, audiologists, and Christian Science practitioners)

Non-practitioner Claims

1. Inpatient Hospital Services
2. Mental Hospital Services for the Aged
3. Outpatient Hospital Services
4. SNF/ICF Mental Health Services for the Aged
5. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under
6. ICF Services for the Mentally Retarded
7. ICF Services - All Other
8. SNF Services
9. Home Health Services (includes personal care services, home/community-based services)

10. Family Planning Services (rendered by a hospital in/outpatient)

11. Sterilization Services (rendered by a hospital in/outpatient)

12. Other Care (transportation, prosthetic devices, durable medical equipment, eyeglasses billed by an optician)

APPENDIX D

Suggested CP Review Control Schedule

APPENDIX D

Suggested CP Review Control Schedule

1. Claim Universe - all claims adjudicated during the review month.
2. Sample Selection - by 15th of the second month.
3. Claims Documentation - by 1st of third month (received in region).
4. CP Review Complete - by 20th of third month.
5. State Notification - by 25th of third month.
6. State Response - by 5th of fourth month.
7. Final Error Determination - by 10th of fourth month.

Whenever possible requests for additional documentation should be made by telephone. There is one fixed date:

> June 15 - Report to central office on 100% of 1st and 2nd quarter samples.

PROCEDURES FOR VALIDATING MEDICAID STATISTICAL DATA

FY 1987

I. Introduction and Overview

The HCFA Medicaid data validation review (DVR) program is designed to determine the capability of State information systems to generate data in accordance with Federal reporting requirements and to detect Medicaid reporting problems resulting from systems design deficiencies. The analysis of State systems consists of examining the outputs, inputs, and processes of State systems used to develop data for Federal statistical reports.

In FY 1984 and FY 1985, a review of State systems for producing the Annual Statistical Report on Medical Care (HCFA-2082) and the Monthly Statistical Report on Medical Care (HCFA-120) identified and resulted in correction of numerous problems in statistical reporting and alerted the States to HCFA's interest in and need for accurate data. Subsequent to the review, these two reports were consolidated into one modified annual HCFA-2082 Medicaid statistical report. In addition to expanding the report from 20 to 47 pages due to inclusion of additional data items, the reporting instructions were modified in terms of type of service and eligibility definitions and method for unduplicating recipients. The revised instructions also allowed States to elect the option of meeting reporting obligations through submission of tape data. This resulted in two categories of State reporting beginning in FY 1986, as follows:

1. Tape Option States - States who elected to submit the required data via tape. Until these States' systems are approved to submit the data in this manner, they are to submit the old HCFA-2082 for control purposes. In the event these States do not meet approval status or volunteer to withdraw, the State will be required to submit the revised hardcopy 2082.

2. Hardcopy States - States who did not elect to use the tape option. These States must submit the revised hard copy of the HCFA-2082 and use the instructions contained in Section 2700.1 of the State Medicaid Manual.

To ensure accurate reporting under the revised instructions, DVRs were conducted in FY 1986 for all Tape Option and Hardcopy States except for those States which dropped out of tape option status and/or did not submit a revised hardcopy HCFA-2082 in FY 1986. A DVR will therefore have to be performed in these few States in FY 1987.

With the exception of these few reviews, the majority of the DVR effort in FY 1987 will involve the monitoring of corrective actions on deficiencies identified in earlier DVRs. Because both central office (CO) and the regional offices (ROs) were involved in the FY 1986 review of the HCFA-2082, the monitoring of corrective actions will require a dual effort between CO and RO staff as explained in Section VI of this guide.

The various steps of the review process for FY 1987 are explained in sections II through V of this guide as listed below:

II. Preliminary Review
III. On-Site Review
IV. Report Development
V. Scoring

II. Preliminary Review

A. General Information

A major factor in the review process is the preliminary research performed. The reviewer should obtain as much information as possible about the area under consideration, such as State systems documentation, current Federal reports and related edits. Comparisons should be made to the State plan to verify that only covered eligibles and services are being reported. After reviewing available information, a list of possible problem areas should be developed. The reviewer should then obtain from the State clarifications and explanations to potential problems noted earlier and be alert to ambiguous areas which may lead to additional problems. Following is a more descriptive explanation of the specific steps that should be followed during the preparation period.

B. Review of Federal Reports Submitted

RO staff should review the most current HCFA-2082 report available to identify potential problem areas. CO will assist the ROs in this regard by producing edits and distributing these to the DVR reviewers. The edits will deal primarily with surface inconsistencies such as columns not adding when they should and invalid relationships among data on various sections of the report. In addition, the RO should review the reports for the reasonableness of data submitted.

C. State Systems Documentation Review

1. Requesting State Systems Documentation

The RO should request that States send them systems documentation relating to development of the form. The essential types of documentation to be submitted are the crosswalks (type of service and recipient) which describe how State data categories are converted into Federal reporting categories, and the feeder reports from which data are extracted to produce the Federal reports. Although HCFA-2082 crosswalks and feeder reports were obtained during the FY 1984 and FY 1985 DVR, they should again be requested due to changes in reporting instructions which now should be reflected on the new documentation submitted. Examples of sample type of service and recipient crosswalk

formats (Attachments A and B) and sample feeder reports (Attachment C) are provided to show the appropriate level of detail to be requested. While States are not required to follow the formats exactly, the same level of detail, however, should be obtained.

2. Crosswalk Review

The crosswalks requested in support of the HCFA-2082 should describe how State data categories are converted into Federal reporting categories. For example, while a State may separately identify podiatrists services for its purposes, HCFA-2082 reporting instructions would require podiatrists services to be reported under Other Practitioners Services. The crosswalk should show that the Other Practitioners Services category does include podiatrists services. In addition to listing which types of State categories are collapsed into Federal categories, the crosswalks should also show the systems logic used to recategorize the State breakouts to meet Federal reporting requirements; i.e., the logical steps that a system would perform to determine the proper categorization of data.

Review of the recipient crosswalk should be emphasized since the majority of the definitional changes were in this area. In addition, those areas of the type of service crosswalk relating to definitions which were modified should also be reviewed more closely.

3. Feeder Report Review

The feeder reports are individual State reports from which data are extracted for the HCFA-2082. In many cases a feeder report is a computer generated report formatted exactly like the HCFA-2082 from which data are retyped onto the Federal form. If more than one feeder report is used, the reviewer should examine the reports to determine if data are properly combined from the various sources. If one report formatted like the HCFA-2082 is used, then the reviewer should compare the feeder report with the data submitted to determine if any changes were made to the computer generated data. If differences are discovered, the State staff should be questioned to determine why the changes were made and if the changes resulted in improper reporting.

III. On-Site Review

At the discretion of the RO staff, on-site visits may be made to each State subject to a revised HCFA-2082 DVR in FY 1987. The scope of the on-site visit will vary depending on the amount of information available at the RO. In general, the on-site visit will include:

1. Reviewing State systems documentation (if not available in RO).

2. Interviewing appropriate State and contractor staff to obtain information needed to complete the validation of specific areas on the HCFA-2082. The reviewer should utilize the interviews to obtain information not available from the review of State systems documentation and sample State reports and to confirm and/or follow-up on information found in the documentation review. Persons to be interviewed should include staff from the State office which is responsible for preparing the HCFA-2082 and State and/or contractor staff responsible for designing and maintaining State information systems.

3. Determining the following information on the State's HCFA-2082 reporting system if not sufficiently addressed during the preliminary review:

   a. Distinguishing Federally Matchable From State-Only Payments

      Determine whether those States that have a State-only medical assistance program (non-title XIX), are separately identifying the data to exclude it from data for title XIX services.

   b. Reporting of All Required Medicaid Data on the Federal Reports

      Determine if there are any required types of Medicaid data not reported on the Federal reports.

   c. Unduplication of Recipients

      Determine if each cell of the applicable sections of the Federal reports contains unduplicated recipient counts. Special attention should be placed on determining if States properly converted from the old to the new method of counting recipients.

   d. Institutionalized Persons

      Determine if the State is selecting the institutionalized population according to instructions and if the State is properly reporting claims for these persons.

Should the RO choose not to make an on-site visit, the RO will need to develop appropriate methods to obtain the information required to conclude a determination on the States' system for reporting statistical data in accordance with Federal requirements.

IV. Report Development

The ROs will be responsible for developing the report of findings for each State reviewed and will include for SPR States, the overall score determined in accordance with Section V.

The RO should submit a preliminary report to the States for their comments. A final report should then be developed taking into consideration State comments. A copy of this final report along with the State comments should be submitted to:

Director
Division of Reports and Analysis
HCFA/BQC/OPQE
Room 239 EHR
6325 Security Blvd.
Baltimore, Md. 21207

DVR results should also be incorporated into the FY 1987 SPR report.

V. Scoring

DVR errors will be categorized based on the "level of error" as either a "primary error," "secondary error," or "tertiary error," with the exception of documentation errors (see A3 below). Each level of error will be assigned a fixed-point value, which reflects the seriousness of the error based on the type of error, the specific data affected by the error, and the degree to which those data are affected.

A. Types of DVR Error

Only systems errors are to be scored on the data validation review. Other types of discrepancies noted on the HCFA-2082 which are found to be the result of clerical errors (such as errors in transcription) should not be scored.

Based on our experience from previous reviews, we have found that DVR errors will fall into the following "types of error."

1. Type of service (TOS) classification error

This type of error occurs when a particular State category of service has been placed into the wrong Federal category or omitted from the report altogether. Each type of service is considered

either major or minor, based on its relative importance, as set forth below:

a. "Major" types of service

Inpatient Hospital	SNF	Outpatient Hospital
ICF-MR	Physicians Services	Prescribed Drugs
ICF-All Other		

b. "Minor" types of service

Mental Hospital-Aged	Other Practitioner	Lab + X-Ray
SNF/ICF-Aged	Clinic Services	Early and Periodic Screening
Inpatient Psych-Under 21	Home Health Services	Rural Health Clinic
Dental Services	Family Planning	Other Care

2. Eligibility classification

This type of error occurs when the State misclassifies or omits categories of eligibles or recipients. Each type of eligible group (Aged, AFDC, etc.) is considered to be of equal importance. Therefore, no distinction is made between "major" and "minor."

3. Documentation errors

This type of error occurs when the State is either unwilling or unable to submit the documentation (e.g., crosswalks and feeder reports) needed to perform the DVR. Where this occurs, this error would automatically equate to an assessment of 1201 DVR points and consequently result in failure of Factor 5I4.

NOTE: When this error occurs, the point values by level of error discussed in "C" below do not apply.

4. Errors in unduplicating eligibles and/or recipients

This type of error occurs when the State fails to unduplicate eligibles and/or recipients in accordance with the reporting instructions.

5. Omission errors

This type of error occurs when the State fails to complete required areas (e.g., columns or rows) of the report.

6. Other errors

These errors would include all errors not falling in one of the above categories.

B. Levels of Error - Definitions

The regional office reviewer will determine the level of error for each deficiency, based on the following guidelines:

1. Primary errors

These errors significantly distort the data reported on the HCFA-2082. Examples of primary errors would be: errors in unduplication; inclusion of State-only recipients or services; gross omissions such as not providing any counts for the "categorically needy -not receiving"; a TOS classification error involving two "major" TOS; etc.

2. Secondary errors

These errors moderately distort the data reported on the HCFA-2082. Examples of secondary errors would be: TOS classification errors involving a "major" TOS and a "minor" TOS; omissions of "minor" types of service; most eligibility classification errors; inability to produce "days of care" or discharge data; etc.

3. Tertiary errors

These errors slightly distort the data reported on the HCFA-2082. Examples of tertiary errors would be: eligibility classification errors involving groups containing fewer than 10 eligibles; minor mathematical discrepancies; TOS classification errors involving only "minor" types of service; etc.

C. Levels of Error - Point Values

Each of the above levels of error will carry a fixed-point value as follows:

1. Primary errors - 250 points each.

2. Secondary errors - 150 points each.

3. Tertiary errors - 50 points each.

D. Limitations

Because different sections of the HCFA-2082 are of varying degrees of importance to HCFA, certain of the above levels of error can be assessed only if the deficiency occurs in specific sections of the report. The

following chart shows which levels of error could occur in each section of the report:

Type of Report	Level of Error: Primary Errors	Secondary Errors	Tertiary Errors
HCFA-2082			
Section A	X	X	X
Section B	X	X	X
Section C	X	X	X
Section D		X	X
Section E		X	X
Section F		X	X
Section G			X
Section H			X
Section I	X	X	X
Section J	X	X	X
Section K		X	X
Section L			X
Section M			X

Using the above chart, one can see that a primary (250 point) error could not be assessed for a deficiency solely affecting days of care data in Section F. The most points that could be assessed for such a deficiency would be 150 points. It would be left to the discretion of the RO reviewer to decide whether 150 points (secondary) or 50 points (tertiary) should be assessed.

Note: The point values assigned are fixed. Only 250, 150, or 50 points can be assessed for a deficiency. Seventy-five (75) points, for example, cannot be assessed. There are no maximum point values per section since more than one deficiency can occur in each section, as can more than one level of error, where applicable.

E. DVR-SPR Conversion Table

A State's validation score is converted to SPR penalty points as follows:

Validation Score	SPR Penalty Points
1 - 200	1
201 - 400	2
401 - 500	3
501 - 600	4
601 - 700	5
701 - 800	6
801 - 1,000	7
1,001 - 1,200	8
1,201 or more	9

The weight of the validation review in the SPR is 1.5.

VI. Monitoring of Corrective Actions

Responsibility for the monitoring of corrective actions in FY 1987 will be divided between CO and RO staff as follows:

A. Tape Option States

1. CO staff will review the documentation sent by the State via the ROs in support of all crosswalk related corrected deficiencies. The results of CO's review will be made available to the ROs together with any required scoring for any deficiencies still outstanding in FY 1987.

2. RO staff will review the supporting documentation for all non-crosswalk related deficiencies and for all deficiencies affecting the HCFA-420 and will determine the scoring for any such deficiencies still outstanding in FY 1987.

B. Hardcopy States

1. RO staff will review the documentation sent by the States in support of all crosswalk, non-crosswalk, and HCFA-420 deficiencies corrected and will determine the score to be applied for any such deficiency still outstanding in FY 1987.

Attachment A

TYPE OF SERVICE CROSSWALK

Federal HCFA-2082 Category	State Category of Service (COS)/Provider Types (PT) Codes	Other Criteria	Description of State COS or PT Codes

Attachment B

ELIGIBILITY/RECIPIENT CROSSWALK

Federal HCFA-2082 Category	State Category of Eligibility Code	Other Criteria	Description of State Category (including CFR reference)

PAGE A29 STATE
STATE
YEAR
FOR HCFA USE ONLY

STATISTICAL REPORT ON MEDICAL CARE: ELIGIBLES, RECIPIENTS, PAYMENTS AND SERVICES FISCAL YEAR
SECTION A (1). AMOUNTS OF MEDICAL VENDOR PAYMENTS BY AGE, RACE ETHNICITY, SEX AND BY TYPE OF MEDICAL SERVICE

TYPE OF MEDICAL CARE OR SERVICES	TOTAL (1)	AGE IN YEARS: UNDER 1 (2)	1 - 5 (3)	6 - 14 (4)	15 - 20 (5)	21 - 44 (6)
1. TOTAL AMOUNT OF EXPENDITURES	68418143	1620226	3060368	4217341	4680289	19654090
2. INPATIENT HOSPITAL SERVICES	11570163	1076392	917987	651413	1200793	4669666
3. MENTAL HOSPITAL SERVICES FOR THE AGED	0	0	0	0	0	0
4. SNF ICF MENTAL HEALTH SERVICES FOR THE AGED	0	0	0	0	0	0
5. INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS AGE 21 AND UNDER	0	0	0	0	0	0
6. ICF SERVICES FOR THE MENTALLY RETARDED	15096350	0	268813	1829483	1926649	8763411
7. ICF SERVICES - ALL OTHER	18451776	0	1068	30812	0	345849
8. SNF SERVICES	8224071	859	11865	12007	30828	441293
9. PHYSICIANS SERVICES	5291330	349963	700644	518562	534483	2014226
10. DENTAL SERVICES	737958	56	141293	349371	227558	10500
11. OTHER PRACTITIONERS SERVICES	200676	15107	11260	20485	16020	72014
12. OUTPATIENT HOSPITAL SERVICES	2707105	77386	402269	327729	253210	1075736
13. CLINIC SERVICES	1120	0	0	0	0	0
14. HOME HEALTH SERVICES	389981	18402	33531	17555	21645	101797
15. FAMILY PLANNING SERVICES	219693	8	451	3761	35569	176539
16. LAB AND X-RAY SERVICES	766005	17991	68081	74249	74551	324182
17. PRESCRIBED DRUGS	2543828	33558	143264	137862	103334	654534
18. EARLY AND PERIODIC SCREENING	131505	14396	71973	41837	3270	20
19. RURAL HEALTH CLINIC SERVICES	21604	1060	3905	3715	3068	8168
20. OTHER CARE	2064973	14963	291957	198573	169604	989593

FORM HCFA-2082

ADJUSTMENTS WITHIN REPORT 1488291 ADJUSTMENTS NOT IN REPORT 20024-

Attachment C

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

CMS LIBRARY
3 8095 00009979 2

BPO-86-088
60m-40402